RE-ISSUE OF THE MANAGED CARE CONTRACT
PROVIDER RISK AGREEMENT

BETWEEN

THE STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

PREMIER BEHAVIORAL HEALTH, L.L.C.

(RE-ISSUE INCLUDES ORIGINAL CONTRACT DATED FEBRUARY 29, 1996 AND AMENDMENTS)

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REISSUE OF CONTRACT

between

THE STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

PREMIER BEHAVIORAL HEALTH, L.L.C.

This CONTRACT is entered into by and between the State of Tennessee, Department of Mental Health and Developmental Disabilities, hereinafter referred to as **"TDMHDD"**, and **Premier Behavioral Health, L.L.C.** hereinafter referred to as the "**Contractor**", for the provision of covered mental health and substance abuse services to **Participants** in the TennCare Partners Program and to certain other persons identified by **TDMHDD**, as described below.

WHEREAS, mental health and substance abuse services are covered under the current TennCare Program; and

WHEREAS, **TDMHDD** provides additional mental health services outside the managed care portion of the TennCare Program which are funded by TennCare, as well as additional mental health services outside the TennCare Program which are funded with state and/or federal funds; and
WHEREAS, it is in the best interests of persons needing mental health and substance abuse services to have them delivered in a coordinated manner by entities experienced in providing managed care services for persons with mental illness and substance abuse problems; and

WHEREAS, it is in the best interests of the state to bring mental health and substance abuse services together in an efficient and effective service delivery system; and

WHEREAS, it is the intent of the state to continue a component of the TennCare Program called the TennCare Partners Program to provide mental health and substance abuse services through a managed care arrangement separate from the TennCare Managed Care Organizations (MCOs); and

WHEREAS, it is the intent of the TennCare Program and **TDMHDD** that **TDMHDD** oversee and administer the TennCare Partners Program; and

WHEREAS, it is the intent of **TDMHDD** to contract with Behavioral Health Organizations (BHOs) for the purpose of delivering mental health and substance abuse services covered by the TennCare Partners Program as well as certain services for specified non-participants; and

WHEREAS, the purpose of this CONTRACT is to assure Tennesseans of quality mental health and substance abuse services while controlling the cost of such mental health and substance abuse services; and

WHEREAS, consistent with waivers granted by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (DHHS), the State of Tennessee has been granted the authority to pay a monthly prepaid capitated amount to BHOs for rendering or arranging necessary mental health and substance abuse services to persons currently enrolled in the State of Tennessee's TennCare Program, which includes Tennesseans who are Medicaid-eligible under the previous Medicaid Program and non-Medicaid-eligible

Tennesseans who are uninsured or are uninsurable as well as certain non-TennCare individuals who are described within the body of this CONTRACT hereinafter referred to as the "TennCare Partners Program"; and

WHEREAS, TDMHDD is the state agency responsible for administration of the Tennessee Partners Program in Tennessee and is authorized to contract with BHOs for the purpose of providing the services specified herein for the benefit of Tennesseans who are eligible for the TennCare Partners Program; and

WHEREAS, the **Contractor** is a Behavioral Health Organization (BHO), has met qualifications established by **TDMHDD**, is capable of providing or arranging for mental health care and substance abuse services to covered persons for whom it has received prepayment, and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof; and

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties have agreed and do hereby enter into this CONTRACT in accordance with the provisions set forth herein.

SECTION 1. PREAMBLE

1.1 Titles

Titles of sections, paragraphs, and clauses used in this CONTRACT are for the purpose of facilitating use or reference only and shall not be construed to imply a contractual construction of language.

1.2 Notice

All notices required to be given under this CONTRACT shall be given in writing, and shall be sent by United States Certified Mail, Postage Prepaid, Return Receipt Requested, in person, or by other means, so long as proof of delivery and receipt is given to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section:

State of Tennessee	Premier Behavioral Systems of Tennessee, L.L.C..
	Charles D. Klusener
Elisabeth Rukeyser	
Commissioner	
Tennessee Department of Mental Health and Developmental Disabilities	
425 5th Avenue North	
3rd Floor, Cordell Hull Building	Chief Manager
Nashville, Tennessee 37243	Premier Behavioral Systems of Tennessee, L.L.C.
	222 Second Avenue North, Suite 220
	Nashville, Tennessee 37201

1.3 Entire CONTRACT

This CONTRACT, including any amendments or attachments, represents the entire CONTRACT between the **Contractor** and **TDMHDD** with respect to the subject matter stated herein. This CONTRACT supersedes any and all other agreements between the parties with regard to the provision of the mental health and substance abuse services described herein. Any communications made before the parties entered into this CONTRACT, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this CONTRACT.

1.4 Amendments

This CONTRACT may be amended at any time as provided in this Section. This CONTRACT shall be amended automatically without action by the parties whenever required by changes in state or federal law with no effect on the compensation due the **Contractor** under this CONTRACT. In the event of a Partial Default, the CONTRACT shall be amended automatically to conform to written notices from **TDMHDD** regarding the effect of the Partial Default upon this CONTRACT. No other modification or change of any provision of the CONTRACT shall be made or be construed to have been made unless such modification is mutually agreed to in writing by the **Contractor**, **TDMHDD**, and HCFA and incorporated as a written amendment to this CONTRACT, and executed by the officials as shown on the signature page hereto.

If significant changes are made in the scope of services under the TennCare Partners Program (other than Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandated services as provided by this CONTRACT), as mandated by actions of the Congress, the state, the State Legislature, HCFA, DHHS or any agency of the state government, **TDMHDD** shall review and adjust the capitation amount accordingly subject to the availability of state appropriations for the mandate.

1.5 Incorporation by Reference

All applicable laws and rules and policies described in Section 6.1 of this CONTRACT and the BHO Application submitted by the **Contractor** are incorporated by reference into this CONTRACT. Any changes in all applicable laws and rules and policies described in this CONTRACT shall be automatically incorporated by reference as soon as they become effective.

1.6 Order of Precedence

If there is a conflict of language or interpretation between this CONTRACT and the following, the order of precedence, from highest to lowest, shall be as follows:

1.6.1 All applicable federal and state laws, and associated properly promulgated federal and state rules and regulations.

1.6.2 This CONTRACT, and any amendment to this CONTRACT.

1.6.3 The terms and conditions of the waivers granted to the State of Tennessee by HCFA to implement the TennCare Partners Program.

1.6.4 The Partners Program Proposal submitted by **TDMHDD** to HCFA.

1.6.5 The BHO Application submitted by the **Contractor**.

1.7 Definitions

The terms used in this CONTRACT shall be construed and interpreted in accordance with the definitions set forth in Attachment A.

1.8 Applicability of this CONTRACT

All terms, conditions, and policies stated in this CONTRACT apply to staff, agents, officers, sub**Contractor**s, providers, volunteers and anyone else acting for or on behalf of the **Contractor**.

TennCare enrollees and certain non- TennCare eligibles identified by **TDMHDD** are the intended third party beneficiaries of contracts between the state and behavioral health organizations and of any subcontracts or provider contracts entered into by behavioral health organizations with subcontracting providers and, as such, **Participants** are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against **TDMHDD** or the State of Tennessee by **Participants** beyond any that may exist under state or federal law.

1.9 Fraud and Abuse

Pursuant to Executive Order 47 (1983), the Tennessee Bureau of Investigation (TBI), Medicaid Fraud Control Unit ("MFCU") is the state agency responsible for the investigation of fraud and abuse in the State Medicaid Program, now the TennCare Program, which encompasses services provided under this CONTRACT.

The **Contractor** shall immediately report to MFCU any suspicion or knowledge of fraud and/or abuse, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return moneys allowed or paid on claims known to be false or fraudulent. The reporting entity including, but not limited to, the **Contractor** shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing MFCU and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation. The **Contractor** and mental health and substance abuse providers with which the **Contractor** contracts shall, upon request, make available to MFCU any and all administrative, financial and medical records relating to the delivery of items or services under this CONTRACT for which moneys are expended. In addition, MFCU must be allowed access to the place of business and to all records of the **Contractor** and mental health care and substance abuse providers during normal business hours, except under special circumstances when after hours admission shall be allowed. Such special circumstances shall be determined at the sole discretion of MFCU.

1.10 Administration and Management

The **Contractor** shall be responsible for the administration and management of all aspects of this CONTRACT and the health plan provided here under. This includes all subcontracts, provider contracts, employees, agents, and anyone acting for or on behalf of the **Contractor**. All subcontracts and revisions thereto, as defined in Attachment A of this CONTRACT, shall be approved in advance by TennCare and must contain either a copy of the Quality of Care Monitors or incorporate the Quality of Care Monitors by reference and must specify that the sub**Contractor** adhere to the Quality of Care Monitors. Provider contracts, as defined in Attachment A of this CONTRACT, shall not require TennCare prior approval but must contain all of the items listed in Section 3.9.2 of this CONTRACT.

However, no subcontract, provider contract or other delegation of responsibility terminates or reduces the legal responsibility of the **Contractor** to TDMHDD to assure all activities under this CONTRACT are carried out.

SECTION 2. TENNCARE PARTNERS PROGRAM DESCRIPTION

2.1 Overview

The TennCare Partners Program is designed to complement the TennCare Program implemented through the State's Section 1115(a) waiver (No. 11-C-99638/4-03). The purpose of the TennCare Partners Program is to provide mental health and substance abuse services to all TennCare enrollees and certain

non-TennCare individuals. The TennCare Partners Program is delivered through BHOs operating under contract to **TDMHDD**.

2.2 Eligibility for Covered Services Under the TennCare Partners Program

2.2.1 Participants

The **Contractor** shall provide covered mental health and substance abuse services in accordance with Section 2.6, as well as court-ordered mental health services in accordance with Section 2.6.5 for individuals enrolled in the TennCare Partners Program.**2.2.1.1** Persons enrolled in the TennCare Program.

2.2.1.2 Persons who are not eligible for the TennCare Program and who are determined by **TDMHDD**, or its designee, to be included among the **Priority Participants**, as defined in Section 2.2.2.2 below. These persons must have family incomes which do not exceed one hundred percent (100%) of the federal poverty level, taking into account the size of the family unit and using the TennCare definitions of the federal poverty level. **TDMHDD**, with the approval of TennCare, may adopt another method for determining household income. These persons will not have coverage through a TennCare managed care organization (MCO).

2.2.2 Categories of Participants

There are two categories of **Participants** in the TennCare Partners Program: **Basic Participants** and **Priority Participants**.

2.2.2.1 Basic Participants

All persons who are enrolled in the TennCare Program, as provided in Section 2.2.1.1, are eligible for the **Basic Benefits Package**. For the purposes of this CONTRACT, such TennCare enrollees, who are not **Priority Participants**, shall be referred to as **Basic Participants**.

2.2.2.2 Priority Participants

All persons, regardless of their enrollment in the TennCare Program, who meet the following criteria as determined by **TDMHDD** or its designee, are eligible for **Enhanced Mental Health Benefits** which include services available to **Basic Participants**. For the purposes of this CONTRACT, all persons who meet the following criteria, as determined by **TDMHDD**, are referred to as **Priority Participants**.

2.2.2.2.1 Severely and/or Persistently Mentally Ill (SPMI)

2.2.2.2.1.1 The person is an adult, aged 18 years or older, and

2.2.2.2.1.2 The person has been diagnosed with a psychiatric disorder in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV),* of the American Psychiatric Association, and

2.2.2.2.1.3 The person has a Clinically Related Group (CRG) rating of CRG 1 or CRG 2 or CRG 3 which has been determined by **TDMHDD** its designee no more than six months prior to the execution of this CONTRACT.

The assessment under this Section shall be performed by persons designated by the BHO who have been trained and who have passed **TDMHDD** competency tests. These persons must use the Clinically Related Group (CRG) assessment form(s) prescribed by and in accordance with the policies of **TDMHDD**. These assessments shall be subject to review and approval by **TDMHDD**.

In the event the **Contractor** fails to provide up-to-date assessments in accordance with Section 2.2.2.2.3.1, the state may transfer responsibility for CRG assessments and up to $2 million from the total available TennCare Partners Program funding on an annual basis to another entity by providing written notice to the **Contractor** thirty (30) calendar days in advance of any transfer of responsibility. In the event the responsibility for the assessments is transferred to another entity, the State, in accordance with Section 5.2.3.7, may adjust the rate specified in Section 4.7.1.1. or the payments made in accordance with Section 4.7.1.2. Notwithstanding this paragraph, upon receipt of notice from **TDMHDD** of the intent of **TDMHDD** to transfer responsibility for assessments to a third party, **Contractor** shall have a reasonable cure period, not to exceed sixty (60) days, to bring all such assessments current.

2.2.2.2.2 Seriously Emotionally Disturbed (SED)

2.2.2.2.2.1 The person is a child or adolescent under the age of 18 years, and

2.2.2.2.2.2 The person has been diagnosed with a psychiatric disorder and a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), of the American Psychiatric Association, and

2.2.2.2.2.3 The person is classified as Target Population Group 2 (TPG 2) which has been determined by **TDMHDD** or its designee no more than six months prior to the execution of this CONTRACT.

The assessment under this Section shall be performed by persons designated by the **Contractor** who have been trained and who have passed **TDMHDD** competency tests. These persons must use the Target Population Group (TPG) assessment form(s) prescribed by and in accordance with the policies of **TDMHDD**. These assessments shall be subject to review and approval by **TDMHDD**.

In the event the **Contractor** fails to provide up-to-date assessments in accordance with Section 2.2.2.2.3.1, the state may transfer responsibility

for TPG assessments and up to $2 million from the total available TennCare Partners Program funding on an annual basis to another entity by providing written notice to the **Contractor** thirty (30) calendar days in advance of any transfer of responsibility. In the event the responsibility for the assessments is transferred to another entity, the State, in accordance with Section 5.2.3.7, may adjust the rate specified in Section 4.7.1.1. or the payments made in accordance with Section 4.7.1.2. Notwithstanding this paragraph, upon receipt of notice from **TDMHDD** of the intent of **TDMHDD** to transfer responsibility for assessments to a third party, **Contractor** shall have a reasonable cure period, not to exceed sixty (60) days, to bring all such assessments current.

2.2.2.2.3 Priority Participant Assessment

2.2.2.2.3.1 Individuals who are **Basic Participants** and who may be eligible for categorization as **Priority Participants** must be assessed by the **Contractor** according to forms prescribed by and in accordance with the policies of **TDMHDD**. Requests for assessments may be made by family members, by mental health or primary care providers, by **TDMHDD**, by the individual's BHO, by the individual's MCO, or by the individual. The **Contractor** must complete these assessments within fourteen (14) calendar days of the request. Assessments, with the **Basic Participant's** consent, are required by the individual's BHO when any of the following circumstances occur. The **Contractor** must complete these required assessments within five (5) working days of each of the following occurrences.

2.2.2.2.3.1.1 The **Basic Participant** has used 40 outpatient mental health benefits in a calendar year.

2.2.2.2.3.1.2 The **Adult Basic Participant** (age 18 or older) has used 15 consecutive or 30 cumulative inpatient psychiatric days in a calendar year.

2.2.2.2.3.1.3 The **Child or Adolescent Basic Participant** (under age 18) has been admitted to an inpatient psychiatric facility/unit.

2.2.2.2.3.1.4 The **Basic Participant** individual is referred for a mental health service in the **Enhanced Benefit Package.**

The **Priority Participant** individual must be reassessed by the **Contractor** at least every six months, or sooner if circumstances warrant.

2.2.2.2.3.2 Individuals who are not **Basic Participants** but who may be eligible for categorization as non-TennCare eligible **Priority Participants** must first apply for TennCare. These individuals may seek assessments from BHOs and receive these assessments in accordance with Section 2.2.2.2.3. Under Section 2.2.2.2.3, assessments and other covered mental health services provided by the BHO after the individual has applied for TennCare but before he or she has been determined to be eligible as a

Priority Participant will be covered under the capitation rate the BHO is paid for that individual should he or she be determined to be eligible as a **Priority Participant** as defined in Section 2.2.2.2.

2.2.2.2.3.3 **Priority Participants** will lose their status as **Priority Participants** when it is determined that they no longer meet the qualifications stated in Subsections 2.2.2.2.1 or 2.2.2.2.2. After assessing the individual and determining the qualifications are no longer met, the **Contractor** shall forward its recommendation on this matter to **TDMHDD**. **TDMHDD**, not the **Contractor**, shall be responsible for deciding a person no longer qualifies as a **Priority Participant**. **TDMHDD** may request additional information from the **Contractor** in making its decision. **TDMHDD** will be responsible for notifying the individual of any adverse decisions and for conducting any appeals that may be made, as specified in Section 3.5.

2.2.3 Judicials

The **Contractor** shall provide court-ordered mental health evaluation and treatment services to **Judicials** who are individuals identified by **TDMHDD** and who are not **Participants** in the TennCare Partners Program. Services which are included in this category are identified in Section 2.6.5. Individuals receiving Judicial Services who are not enrolled in TennCare nor participate in the BHO plan by **TDMHDD** determination are defined as **Judicials. Judicials** are entitled only to coverage of those mental health evaluation and treatment services required by the statute or court order under which the individual was referred.

2.3 Enrollment Guidelines

2.3.1 Enrollment of TennCare Eligibles

Persons who are TennCare eligible will be automatically enrolled in the TennCare Partners Program. All enrollment, disenrollment, and re-enrollment policies of TennCare apply to TennCare enrollees participating in the TennCare Partners Program. TennCare enrollees will be assigned to one of the BHOs participating in the TennCare Partners Program in accordance with Section 2.3.2 below.

For purposes of eligibility for the **Enhanced Benefits Package**, all children under the age of 21 are eligible for medically necessary enhanced benefits in accordance with federal EPSDT requirements. For purposes of eligibility for the **Enhanced Benefits Package**, all adults age 21 and older are eligible for medically necessary enhanced benefits at the time they have been assessed as CRGs 1, 2 and 3. Eligibility for **Enhanced Benefits** shall end only when the adult individual has been re-assessed and found to no longer belong in CRGs 1, 2 or 3, in accordance with Section 2.2.2.2.3.3.

2.3.2 Assignment to BHOs

2.3.2.1 TennCare Partners Program **Participants** will be assigned to the BHOs in the following manner:

a. **Participants** enrolled in the TennCare Program will be assigned to a BHO, including the **Contractor**, based on the TennCare Managed Care Organization (MCO) in which s/he is enrolled. TennCare will assign each MCO to a BHO.

b. **Priority Participants** will be assigned to the BHOs including **Contractor,** by TennCare.

2.3.2.2 TennCare will make a reasonable effort to assign families to the same BHO. The **Contractor** will accept **Participants** assigned to its plan by TennCare. These **Participants** will be accepted in the health condition they are in at the time of enrollment. **TDMHDD** and TennCare reserve the right to change a **Participant's** BHO assignment when such a change is determined to be in the best interests of **TDMHDD** and or **Participants**.

2.3.3 Choice of Providers by Participants

The **Contractor** shall allow each **Participant** to choose his/her own mental health care and substance abuse service providers from the providers participating in the **Contractor's** provider network, subject to the capacity of the providers to accept **Participants**.

2.3.4 Judicials

Judicials will be assigned to BHOs participating in the TennCare Partners Program by **TDMHDD**. Their assignment as **Judicials** will end when the court ordered mental health service as described in Section 2.6.5 has ended, or the person is identified as eligible for the TennCare Partners Program.

2.4 Disenrollment from the TennCare Partners Program

2.4.1 Disenrollment Guidelines

The **Contractor** will discontinue covered services to **Participants** who are disenrolled from the TennCare Partners Program in accordance with TennCare Rule 1200-14-12-.03 of the Tennessee Department of Finance and Administration (TDFA).

2.4.2 Unacceptable Reasons for Disenrollment

A **Participant** may not be terminated from the TennCare Partners Program or a designated BHO plan solely for any of the following reasons:

2.4.2.1 Adverse changes in the **Participant's** health;

2.4.2.2 Pre-existing medical conditions; or

2.4.2.3 High cost medical bills.

2.4.3 Effect of Disenrollment on Capitation Payments

Payment of capitation payments shall cease effective the date of disenrollment and the **Contractor** shall have no further responsibility for the care of the **Participant**. Except as indicated below, disenrollment shall not be made retroactively and the **Contractor** shall not be required to refund any capitation payments legitimately paid pursuant to this CONTRACT.

2.4.3.1 Fraudulent enrollment by the Participant

If a **Participant** in the TennCare Partners Program is disenrolled under Subsection 2.4.1 because s/he falsified the application for the TennCare Partners Program and approval was based on false information, payment of capitation payments shall cease effective the date of disenrollment. However, the **Contractor**, at its discretion, shall refund to TennCare all capitation payments TennCare has made on behalf of the person who fraudulently enrolled in the TennCare Partners Program, and the **Contractor** shall pursue full restitution for all payments the **Contractor** has made for covered services while the person was fraudulently enrolled in the **Contractor**'s plan.

2.4.3.2 Fraudulent enrollment by the Contractor

In the event of fraudulent enrollment or attempted enrollment of individuals by the **Contractor**'s staff, officers, sub**Contractor**s, providers, volunteers or anyone acting for or on behalf of the **Contractor**, TennCare shall retroactively recover capitation amounts and any other moneys paid to any BHO for the enrollment of that individual.

2.4.4 Contractor's Responsibilities for Disenrollment

The **Contractor**'s responsibilities for disenrollment are as follows:

2.4.4.1 Inform each **Participant** at the time of enrollment of the criteria for disenrollment from the plan as permitted by Section 2.4.1 of this CONTRACT:

2.4.4.2 Inform TennCare promptly when the **Contractor** knows or has reason to believe a **Participant** may satisfy any of the conditions for disenrollment described in Section 2.4.1. Every six months the Contractor shall demonstrate in writing to the satisfaction of **TDMHDD** that all non-TennCare **Priority Participants** still qualify for the TennCare Partners Program. Such demonstration shall include, but not be limited to, evidence that the **Participant** continues to receive services under the TennCare Partners Program.

2.4.4.3 TennCare shall provide to the **Contractor** a report of all disenrollments resulting from action taken by TennCare. This report shall delineate by county of residence, in county order, all persons disenrolled, the effective date of their disenrollment and the reason for their disenrollment. This report shall be available to the **Contractor** each month as these disenrollments occur. Actions taken by TennCare cannot be grieved by the **Contractor**.

2.5 Re-enrollment in the TennCare Partners Program

2.5.1 Individuals who have lost TennCare eligibility and who are seeking re-enrollment in the TennCare Program shall be re-enrolled in the TennCare Partners Program at the time TennCare determines they may be re-enrolled in the TennCare Program.

2.6 Services Covered Under the TennCare Partners Program

2.6.1 Covered Services

The **Contractor**'s service system shall provide a uniform and consistent continuum of quality mental health and substance abuse services statewide which includes the active involvement of the **Contractor**'s Advisory Board. The **Contractor** shall provide for **TDMHDD** approval a three-year plan for service development which includes a method for determining the types and levels of service needs; a method for determining resource needs; and a plan for development of new service technology. The **Contractor** shall provide services identified in the service categories in the **Basic Benefits Package** for enrollees identified as **Basic Participants** in need of mental health and/or substance abuse services and services identified in the service categories in the **Enhanced Benefits Package** for persons identified as **Priority Participants** in need of mental health and/or substance abuse services, as referenced in Table 1. The **Contractor** shall provide court ordered services as described in Section 2.6.5 for persons designated to receive specific mental health services as **Judicials** as described in Section 2.2.3. The **Contractor** must provide service categories and covered services which meet the standards described in Attachment B. In accordance with EPSDT requirements, the **Contractor** shall provide medically necessary services to children under the age of twenty-one (21) when such services are required to correct or ameliorate mental illnesses and conditions, whether or not such services are covered under the TennCare Program state plan and without regard to any service limits otherwise established in this CONTRACT. This requirement shall be met by either direct provision of the service by the **Contractor** or by referral in accordance with 42 CFR 441.61. For children in Target Population Group (TPG) 1, additional services beyond the service limits in the **Basic Benefits Package** will be provided through the Department of Children's Services (DCS).

2.6.1.1 Medically Necessary Services

The **Contractor** shall cover, at a minimum, the following services and benefits consistent with and in accordance with the Title XIX Medicaid State Plan in existence as of December 31, 1993 and Title XIX C.F.R. requirements governing benefits and Sections 5.01 through 5.03 of Article V of the State of Tennessee Comprehensive Medical and Hospitalization Program Plan benefits as it existed December 31, 1993, subject to any applicable limitations described in this Agreement. The **Contractor** shall not impose utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each enrollee and his or her medical history. The provision shall not limit the **Contractor's** ability to establish procedures for the determination of medical necessity, so long as determinations of medical necessity are consistent with the definition of medical necessity as described in this Agreement and based upon an enrollee's individual needs and medical history and based upon substantial and material evidence. When the state finds the **Contractor** is imposing arbitrary utilization guidelines, the **Contractor** shall immediately provide the covered service in the quantity and for the duration prescribed, subject to the **Contractor** right to reduce or terminate the service in accordance with the procedures required by TennCare Rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective. The state shall also assess liquidated damages in accordance with Section 5.3.3.

Table 1

Mental Health and Substance Abuse Benefits Under the TDMHDD Partners Program

Mental Health and Substance Abuse Benefits	Basic Benefit Package (all benefits must be medically necessary)	Enhanced Benefit Package (for those in the Priority Population) ⇒
Psychiatric Inpatient Facility Services		
Under 21 ❻	As medically necessary	As medically necessary
Age 21-65	Limited to 30 days per occasion, 60 days per year per enrollee	As medically necessary
Over 65	As medically necessary	As medically necessary
Physician Psychiatric Inpatient Services	As medically necessary	As medically necessary
Outpatient Mental Health Services	As medically necessary.	As medically necessary (no lifetime dollar limit)
Inpatient and Outpatient Substance Abuse Treatment Services Includes Methadone Detoxification and Methadone Maintenance and Treatment of Pain, as Medically Necessary	• 10 days detox❷ • Inpatient and outpatient substance abuse benefits have a maximum lifetime limitation of $30,000❷	As medically necessary (no lifetime dollar limit)
Psychiatric Pharmacy Services and Pharmacy-Related Lab Services❺	As medically necessary	As medically necessary
Transportation to Covered Mental Health Services	As medically necessary for enrollees lacking accessible transportation The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.	As medically necessary for enrollees lacking accessible transportation The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.

Mental Health Case Management		Must be offered to all persons with assessments of CRG 1, CRG 2 or TPG 2. As clinically indicated for CRG 3.
24-Hour Residential Treatment		As medically necessary
Housing/Residential Care❹		As medically necessary
Specialized Outpatient and Symptom Management		As medically necessary
Specialized Crisis Services	As medically necessary	As medically necessary
Psychiatric Rehabilitation Services		As medically necessary

If medically appropriate for the patient, the BHO may authorize substitution of outpatient days, partial hospitalization days, or residential treatment days for covered psychiatric inpatient facility days. Two substitute days will count as one inpatient day. No substitute day may be counted toward any other benefit limit.

❷In accordance with federal EPSDT requirements, the **Contractor** shall be required to exceed service limits when medically necessary for children under the age of 21.

When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.

❹Housing/Residential Care is a covered service only when medically necessary for an individual's living environment to be supervised, structured and/or assisted by mental health staff.

❺The state is financially responsible for all pharmacy services as described in Section 3.4.10 of this CONTRACT.

❻Assessment as a **Priority Participan**t shall not be required for enrollees under age 21 in order for the enrollee to receive medically necessary services in the **Enhanced Benefit Package.**

2.6.2 Accessibility and Availability of Services:

2.6.2.1 The **Contractor** shall make services, service locations and service sites available and accessible in terms of timeliness, amount and duration. The **Contractor**'s provider network shall contain a sufficient number of appropriately qualified providers to insure the access standards stated in Attachment B are met for all enrollees in the **Contractor**'s plan. Emergency mental health and substance abuse services shall be available twenty-four (24) hours a day, seven (7) days a week.

2.6.2.2 Minimum standards for this CONTRACT are:

2.6.2.2.1 The **Contractor** must provide all of the services defined as covered in Section 2.6 of this CONTRACT.

2.6.2.2.2 There shall be a sufficient number of providers of mental health and substance abuse services within each geographic area of the State. Providers must be strategically located so no **Participant** has to travel distances in excess of those provided in Attachment B of this CONTRACT.

2.6.2.3 The **Contractor** must provide the availability of services of specialists, on at least a referral basis, as deemed medically necessary to meet the access requirements contained in Section 2.6.2.1 and Attachment B of this CONTRACT.

2.6.2.4 The **Contractor** shall insure it provides accessible and available services covered under this CONTRACT for all **Participants**, including those belonging to special groups. These special groups include, but are not limited to, the following:

2.6.2.4.1 Individuals with physical disabilities such as hearing loss or vision impairment;

2.6.2.4.2 Dual diagnosed individuals (those with diagnoses of mental illness as well as diagnoses of mental retardation or substance abuse);

2.6.2.4.3 Homeless individuals;

2.6.2.4.4 Persons involved with the juvenile or adult judicial system;

2.6.2.4.5 The geriatric population;

2.6.2.4.6 Preschool children from birth to age 6 who have experienced neglect, abuse, severe environmental trauma, or other life circumstances which threaten normal child development; and

2.6.2.4.7 Children and youth who have committed sexual offenses against others using any type of force or coercion.

2.6.2.5 The **Contractor** must assure appropriate services in the categories of (1) Mental Health Case Management, (2) 24-hour Residential Treatment, (3) Housing and Other Residential Care, (4) Specialized Outpatient and Symptom Management Services, (5) Psychiatric Rehabilitation Services, and (6) Specialized Crisis Services are addressed in the development of the mental health case management service plan for each person who is a **Priority Participant**. Unless it is documented that service need in that service category is not indicated for the individual **Priority Participant**, the **Contractor** must offer appropriate service in each category to each **Priority Participant.**

Except as otherwise required in this CONTRACT, the **Contractor** shall not be responsible for coverage of treatment services to any **Participant** when the need for treatment services is the result of factors other than the **Participant's** mental health or substance abuse treatment needs.

2.6.3 Mental Health and Substance Abuse Maximum Lifetime Limitations

Basic Benefits Package	**Maximum Lifetime Benefits**
Outpatient Mental Health Services (including physician services)	As medically necessary
Substance Abuse Benefits (Inpatient and Outpatient)	$ 30,000, including a maximum of 10 days detox

Enhanced Benefits Package	**Maximum Lifetime Limitations**
Outpatient Mental Health Services (including physician services)	No lifetime dollar limit
Inpatient and Outpatient Substance Abuse Treatment Services	No lifetime dollar limit
Mental Health Case Management Required service	No lifetime dollar limit
All other enhanced mental health services for **Priority Participants**	As medically necessary No lifetime dollar limit

In accordance with federal EPSDT regulations, these limits shall not apply to children under twenty one (21) years of age. They also shall not apply to adults, 21 years of age or older, who have been identified as belonging in the **Priority Population.**

2.64 Mental Health Case Management

2.64.1 The **Contractor** will provide mental health case management services only through Mental Health Case Management Agencies (MHCMA) providers which are licensed by **TDMHDD** to provide mental health outpatient services.

2.6.4.2 The **Contractor** will provide mental health case management services according to mental health case management agency standards set by **TDMHDD** outlined in Attachment B. These standards include, but are not limited to, the following: the process the **Contractor** will establish for referral for mental health case management; the criteria and process for assigning a **Priority Participant** to mental health case management, including rationale for how priority will be determined (this process must reflect **TDMHDD** requirements specified in Section 2.6.4.4); the criteria and process for assigning an individual to a mental health case manager; the process used to determine the intensity level of mental health case management a **Priority Participant** will receive; the process for determining how a mental health case manager's caseload size will be determined; the identification of service need; development of a mental health case management service plan; authorization of services outlined in the mental health case management service plan; monitoring of progress; and advocacy and coordination with other agencies, particularly with primary health care providers.

2.6.4.3 The **Contractor** must offer mental health case management to all **Priority Participants** enrolled in the **Contractor's** plan in accordance with the timeframes specified in Section 2.6.4.4. The accessibility and availability of these services must be thoroughly explained. Any **Priority Participant** who meets the criteria outlined in Attachment B may choose to decline mental health case management services or to terminate these services once they

have begun; however, the **Contractor** must document this refusal with a statement signed by the **Participant** (or the **Participant's** conservator or guardian) which contains the following components:

2.6.4.3.1 A statement that the **Participant,** is eligible for and based on medical necessity, has been offered mental health case management services.

2.6.4.3.2 A statement explaining mental health case management services provide support 24-hours a day, 365 days a year and provide assistance in accessing an array of services.

2.6.4.3.3 A statement that the **Participant** refuses mental health case management services at this time but can receive mental health case management services at a later date if he or she so chooses and if the services are determined to be medically necessary.

2.6.4.3.4 Information on whom the **Participant** can contact in order to request mental health services in non-emergency situations.

2.6.4.3.5 A signature and date from the **Participant** (or the **Participant's** conservator or guardian) and a witness.

2.6.4.3.6 If a **Participant** who does not have a conservator or guardian refuses to sign the mental health case management waiver or statement of refusal, the **Contractor** shall require the signature of two witnesses attesting to the **Participant's** refusal to sign.

2.6.4.4 The **Contractor** must assure the continual provision of mental health case management services to **Priority Participants** as defined in Section 2.2.2.2 under the conditions and timeframes indicated below:**2.6.4.4.1** Individuals receiving mental health case management services at the date of execution of this CONTRACT must be maintained in mental health case management until such time as the individual no longer qualifies as a **Priority Participant;**

2.6.4.2 Individuals discharged from psychiatric inpatient facilities and Mental Health Residential Treatment Facilities must be offered case management services and provided with appropriate mental health follow-up services as specified in Subsection 3.4.3.2.3;

2.6.4.4.3 All adults with a CRG assessment of 1 or 2 and all children and adolescents with a TPG assessment of 2 must be offered mental health case management services in accordance with Attachment B. Adults with a CRG 3 shall be offered mental health case management services as clinically indicated.

2.6.4.4.4 The **Contractor** must maintain a current record of **Priority Participants** who are waiting to receive mental health case management services and the reasons why they are waiting.

2.6.4.4.5 The **Contractor** must submit quarterly reports as specified by **TDMHDD** detailing the number of **Participant** members of the **Priority Population** who have refused mental health case management services. No person may be terminated from mental health case management services unless that person

refuses the services in accordance with Section 2.6.4.3 or unless the person has been re-assessed by the **Contractor** and found by **TDMHDD** to no longer be a **Priority Participant**, in accordance with Subsection 2.2.2.2.3.3 or may have been terminated from case management services.

2.65 Judicial Services

The **Contractor** must provide covered court ordered mental health services to **Participants** in the TennCare Partners Program and to **Judicials** at the direction of the court in accordance with **TDMHDD** service standards and **TDMHDD** forensic standards.

2.6.5.1 Services Required under Tennessee Law

2.6.5.1.1 The **Contractor** shall provide for the care of **Participants** and **Judicials** under Tennessee law. Specific laws employed include the following:

2.6.5.1.1.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (Tennessee Code Annotated, §33-6-103 and 104); The **Contractor** may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release.

2.6.5.1.1.2 Judicial review of discharge for persons committed involuntarily by a criminal or juvenile court (Tennessee Code Annotated, §33-6-110);

2.6.5.1.1.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being committed involuntarily (Tennessee Code Annotated, §33-6-201);

2.6.5.1.1.4 Inpatient psychiatric examination for up to 48 hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (Tennessee Code Annotated, §33-3-607); and

2.6.5.1.1.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of accommodations (Tennessee Code Annotated, §33-6-101).

2.6.5.1.1.6 (Effective March 1, 2001) *Voluntary psychiatric hospitalization for persons who are severely impaired when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA, 33-6, Part 3)*

2.6.5.1.2 The **Contractor** must not discriminate against a **Participant** based on the law that may govern **Participant's** care.

2.6.5.1.3 The **Contractor** shall identify and assign specific staff to provide legal and technical assistance for (see 2.6.5.3.3 below) and coordination with the legal system for services provided in these categories.

2.6.5.2 Forensics

2.6.5.2.1 The **Contractor** must provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following 60-90 day inpatient evaluation. Treatment can be terminated only by the court. [Tennessee Code Annotated, §33-7-303(b)]

2.6.5.2.2 The state will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.6.5.2.1.

2.6.5.3 Other Requirements under Tennessee Law

2.6.5.3.1 The **Contractor** shall provide for the care of **Participants** and **Judicials** under Tennessee law requiring access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being committed involuntarily (Tennessee Code Annotated, §33-6-201 *et seq.* and §33-7-301(b)).

2.6.5.3.2 The **Contractor** must not discriminate against a **Participant** or a **Judicial** based on any law that may govern the **Participant's** or **Judicial's** care.

2.6.5.3.3 The **Contractor** shall identify and assign specific staff to provide legal and technical assistance for and coordination with the legal system for services provided in these categories.

2.6.6 Crisis Services Telephone Lines

2.6.6.1 The **Contractor** must coordinate and establish with other BHOs participating in the TennCare Partners Program one (1) widely published toll free telephone number for any individual in the general population (**Participants**, family members, providers, non-**Participants**, etc.) per Community Health Area (CHA) region as appropriate, for the purposes of immediate phone intervention by mental health staff and dispatch of mobile crisis services in the appropriate community. The same toll free telephone number may be used in multiple CHAs. This specialized telephone line will be answered by a staff person, rather than by an automated voice response system.

2.6.6.2 The **Contractor** must assure the Crisis Telephone lines are available 24-hours per day, 365 days per year.

2.6.6.3 The **Contractor** must assure the Crisis Telephone lines are linked to a crisis response team and are staffed by a qualified mental health staff person for the purpose of providing immediate phone intervention and immediate dispatch of mobile crisis services in the appropriate community.

2.6.7 Specialized Housing Services

2.6.7.1 The **Contractor** must coordinate and establish with other BHOs participating in the TennCare Partners Program housing services as described in Attachment B.

2.6.7.2 The **Contractor** must meet the transition requirements specified in Subsection 3.4.5.7.3 regarding supportive housing as described in Attachment B.

2.6.7.3 In cooperation with the other BHOs participating in the TennCare Partners Program, the **Contractor** must minimally maintain current housing availability of one (1) bed per 10,000 general population statewide for adults who are **Priority Participants**.

2.6.7.4 The **Contractor** must develop additional appropriate housing alternatives for SPMI individuals who are receiving inpatient psychiatric facility services but who no longer require acute inpatient care and who could leave the facility if appropriate housing services were available. Plans for housing alternatives must be submitted to **TDMHDD** for review and approval prior to implementation. The **Contractor** shall provide **TDMHDD** with monthly updates of the progress made in the development and implementation of additional appropriate housing alternatives.

2.6.8 Services Not Covered

The **Contractor** is not obligated to pay for non-covered services in accordance with TennCare Rule 1200-13-12-.10 of TDFA.

2.6.9 Special Requirements Regarding Children

The **Contractor** will participate fully in the implementation of the Remedial Plan for Children in state custody. "Participation" includes, but is not limited to, the following requirements:

2.6.9.1 The **Contractor** must have a contract with each Children's Center of Excellence (COE) for provision of tertiary level medically necessary covered services to Department of Children's Services DCS custody children and children at risk of DCS custody. Such services shall include ongoing specialized care when requested by local providers managing the child's care; and case coordination of services offered. Children will be referred to the COE when required specialists with appropriate training and experience are not available. The COE can determine when a specialist can serve as a primary care provider (PCP) on special cases where this is deemed in the child's interest and the specialist is willing to accept this role. The COE can also determine whether a service which has been ordered for a DCS custody child and which has been denied by the **Contractor** can be initiated while an appeal is still pending. The **Contractor** will share its utilization guidelines with the COE to improve understanding and cooperation.

2.6.9.2 The **Contractor** will contract with the DCS Primary Treatment Centers (PTC) for delivery of medically necessary covered behavioral health services residing in these centers.

2.6.9.3 The **Contractor** must maintain a provider network with adequate capacity to deliver covered services which meet the special needs of children in state custody. Indicators of an adequate network include the following:

2.6.9.3.1 The **Contractor** has enough Best Practice Network (BPN) providers to consistently meet the timeline of scheduling initial behavioral health screenings

for DCS custody children when referred by the PCP and behavioral assessments as medically necessary;

2.6.9.3.2 The **Contractor** has sufficient providers to be able to consistently deliver services to custody children ordered by a provider in its own network, a BPN provider, or a COE within the timeframes set out elsewhere in the CONTRACT; and

2.6.9.3.3. The **Contractor** has within its network specialized health providers with sufficient expertise to deliver the covered services recognized in Best Practice Guidelines (BPG) as being proven effective and needed by children in custody.

2.6.9.4 The **Contractor** must contract with all BPN providers unless it can demonstrate to the satisfaction of the Implementation Team that its existing network is adequate. If a **Contractor** can demonstrate to the satisfaction of the Implementation Team its network partially satisfies the adequacy requirements (e.g., in a particular geographic area or medical specialty) but not entirely, the Implementation Team, at its discretion, can excuse the **Contractor** from contracting with BPN providers in those areas in which the **Contractor's** network is adequate.

2.6.9.5 The COE may order TennCare covered services for children whom it is treating or diagnosing. The COE must follow the **Contractor's** procedures with respect to requests of prior authorization, etc. If the **Contractor** denies coverage of the service but the COE believes the service should be delivered, the COE can begin the service or arrange for a provider in the **Contractor** network to begin the service. The provider to be used will be discussed with the **Contractor** to assure that provider is still a participant in the **Contractor's** network and in good standing with the **Contractor.** If an appropriate provider is not available within the network to provide the service in a timely fashion, then the COE can select an out-of-network provider. (The Implementation Team can also approve an out-of-network provider for children at risk of state custody under the same conditions listed for the COEs.) The COE will initiate an expedited appeal for the service. If the appeal decision determines the **Contractor** is responsible for providing the service, then the **Contractor** will pay for the service. If the appeal decision determines the **Contractor** is not responsible for providing the service, then the state will pay for the service and will not claim Federal Financial Participation (FFP) for this expenditure.

2.6.9.6 If a BPN provider requests a service that requires prior authorization and the service is denied by the **Contractor**, then:

2.6.9.6.1 The BPN provider will contact the COE and review the case with a faculty member for medical necessity.

2.6.9.6.2 If the COE concurs with the **Contractor** that the service is not medically necessary or not covered, the COE will work with the BPN provider to assess whether an alternative service is necessary and, if so, to determine an alternative, but appropriate, service to order;

2.6.9.6.3 If the COE concurs with the BPN provider that the ordered service is covered and medically necessary, then the COE will contact the **Contractor** for approval;

2.6.9.6.4 If the **Contractor** denies coverage of the service, the COE can begin to provide the service or authorize a provider of the **Contractor** network to begin the service; and

2.6.9.6.5 The COE will begin an expedited appeal for the service. If the appeal decision determines that the **Contractor** is responsible for providing the service, then the **Contractor** will pay for the service. If the appeal decision determines the **Contractor** is not responsible for providing the service, then the state will pay for the service and will not claim FFP for this expenditure.

2.6.9.7 When a covered service has been ordered by a behavioral health provider for a child at risk of custody and the **Contractor** has denied the service but approved a less intensive service which the provider, the DCS case manager, and the psychologist in the DCS Health Unit believe is inadequate to keep the child out of custody, the Implementation Team will be contacted for disposition:

2.6.9.7.1 If the Implementation Team determines the **Contractor** approved service plus DCS family support services are adequate, at least for a trial, then no change will be made. (If the trial fails in the judgment of the DCS staff, the Implementation Team can be contacted for reassessment of the situation.)

2.6.9.7.2 If the Implementation Team agrees with the provider and DCS staff that a more intense service is needed, the Implementation Team will initiate the COE-approved services. Where practicable, the Implementation Team will use a qualified provider in the **Contractor's** network. However, a network provider will not be used if the Implementation Team, in the exercise of its sole discretion, determines any of the following:

2.6.9.7.2.1 There is not time to locate a network provider under the circumstances;

2.6.9.7.2.2 A network provider is not available to provide the services in a timely fashion;

2.6.9.7.2.3 Available network providers are not qualified to deliver needed services; or

2.6.9.7.2.4 Using a network provider would otherwise jeopardize the health of the child in need of services.

2.6.9.7.3 Whenever the Implementation Team initiates the COE-approved services under this provision, the Implementation Team will notify the **Contractor** of the decision and will file an appeal. Should the decision on appeal be in favor of the **Contractor,** the state will be responsible for reimbursement of those services. Should the decision be rendered against the **Contractor**, the **Contractor** will be assessed the cost of the service denied.

2.6.9.8 When, pursuant to the Remedial Plan for Children in Custody, services are provided when deemed appropriate regardless of **Contractor** denial, the **Contractor** will be allowed to appeal decisions found against it to a neutral party designated by the state. However, the outcome of the process shall not affect the interests of the child, who shall receive the services in question without regard to whether the **Contractor** or a state agency is ultimately determined to be financially responsible.

SECTION 3. Contractor Responsibilities

3.1 General

The **Contractor** must comply with all the provisions of this CONTRACT and any amendments thereto and must act in good faith in the performance of these provisions. The **Contractor** must respect the legal rights of the individual (including rights conferred by the CONTRACT and Title 33, Tennessee Code Annotated) of every **Participant**, regardless of the individual's family status as head of household, dependent, or otherwise. Nothing in this CONTRACT may be construed to limit the rights or remedies of **Participants** under state or federal law. The **Contractor** acknowledges failure to comply with the above referenced provisions may result in the assessment of liquidated damages and/or termination of the CONTRACT in whole or in part, and/or imposition of other sanctions as set forth in this CONTRACT.

3.2 Contractor Qualifications

The **Contractor** must comply with the following requirements at the inception of this CONTRACT and at all times during the life of this CONTRACT:

3.2.1 Agree to on-site review by **TDMHDD** before final execution of this CONTRACT;

3.2.2 Agree to accept all **Participants** and **Judicials** assigned to the **Contractor** whatever reason and a reasonable number of **Participants** from any failed **Contractor** pursuant to Section 3.4.9 of this CONTRACT;

3.2.3 Agree to not require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare or non-**TDMHDD** plan operated or administered by the **Contractor;**

3.2.4 Meet and maintain the administrative requirements of Tennessee Department of Commerce and Insurance (TDCI) as specifically set forth in this CONTRACT or applicable statute;

3.2.5 Establish and maintain adequate risk reserves, as specified in Section 3.3.2;

3.2.6 Be appropriately licensed, if required by the laws of Tennessee, to ensure the **Contractor**'s financial viability to perform its obligations under this CONTRACT to operate within the State of Tennessee;

3.2.7 Be properly registered with the Secretary of State to do business in Tennessee;

3.2.8 Have adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of consumers and families, staff, facilities, and the general public;

3.2.9 Have documented experience with private and public mental health and substance abuse service delivery systems and their participants;

3.2.10 Provide evidence of successful experience with other similar contracts;

3.2.11 Maintain a sufficiently staffed and working office within the State of Tennessee, including a full-time Tennessee-based administration as described in Section 3.7 specifically identified to administer the day-to-day business and programmatic activities of this CONTRACT;

3.2.12 Demonstrate the capacity to develop, manage, and maintain good local/regional relations with providers to enhance provider recruitment and retention, as evidenced by the Provider Relations Plan described in Section 3.85;

3.2.13 Measure and report utilization, cost, quality, and patient satisfaction data through a management information system that supports the specific administrative and clinical decision making required for delivery of mental health and substance abuse services;

3.2.14 Provide high quality administrative and clinical leadership in the provision of mental health and substance abuse services.

3.2.15 Implement a Quality Monitoring Plan (QMP) in accordance with **TDMHDD** requirements;

3.2.16 Interact effectively with providers in all regions of the state;

3.2.17 Maintain service accessibility and availability through the existence of a current Statewide network of appropriately licensed and credentialed mental health and substance abuse providers capable of providing 24-hour comprehensive mental health and substance abuse services to a minimum of 400,000 Participants;

3.2.18 Produce acceptable provider contracts and letters of referral with mental health and substance abuse providers which are at a minimum one (1) year in duration, with cancellation clauses of no less than 60 days consistent with the terms of this CONTRACT and any amendments thereto.

3.2.19 Provide mental health case management in accordance with standards set by **TDMHDD**;

3.2.20 Identify persons in need of CRG/TPG assessments, providing these assessments promptly and accurately, and following up on identifications with treatment plans and re-assessments as necessary;

3.2.21 Manage mental health and substance abuse provider networks: recruit, credential, enroll, train, and manage providers and maintain positive provider relationships;

3.2.22 Make smooth transitions of consumers from one provider to another when there are changes in providers;

3.2.23 Determine that all providers have adequate and appropriate insurance coverage and/or sovereign immunity in all necessary areas;

3.2.24 Provide adequate telephone availability of mental health and substance abuse professionals 24-hours a day, 7 days a week;

3.2.25 Provide appropriate and effective mental health services to the special populations described in Section 2.6.2.4;

3.2.26 Meet access and availability requirements for services defined in Attachment B and as referenced in Section 2.6.2;

3.2.27 Utilize standardized billing forms and procedures for all transactions.

3.2.28 Maintain sufficient information system (IS) capability to provide enrollee eligibility information to participating providers.

3.2.29 Have the ability to accept electronic billing from providers.

3.2.30 Pay or appropriately deny 95% of the total number of clean claims from both contract and non-contract providers within thirty (30) calendar days of receipt, pay or appropriately deny the remaining 5% of the total number of clean claims within the next 10 days, and process all claims submitted by contract and non-contract providers within sixty (60) calendar days of receipt described in Section 3.13.2;

3.2.31 Demonstrate commitment to **Participant** involvement in treatment decisions;

3.2.32 Provide for involvement of **Participant** advocacy from both consumers and their families and provide opportunities for advocacy groups to review plan and service performance;

3.2.33 Provide a responsive appeal process, both formal and informal; as specified in Section 3.5;

3.2.34 Provide specialized crisis services and coordinate with other BHOs participating in the TennCare Partners Program to provide one (1) widely published toll free number for the general population per CHA region for the purposes of providing immediate phone intervention and immediate dispatch of mobile crisis services in the appropriate community, as specified in Section 2.6.6 (the same toll-free number may be used in multiple CHAs). This specialized telephone line will be answered by a staff person, rather than by an automated voice response system;

3.2.35 Measure mental health and substance abuse outcomes, and evaluate improvement in mental health status, **Participants'** functioning and sense of well-being;

3.2.36 Conduct mental health and substance abuse health outcome research studies;

3.2.37 Routinely assess provider and **Participant** satisfaction and demonstrate this information is used to improve services; and

3.2.38 Mutually agree to such other requirements as may be reasonably established by TennCare, TDCI, or **TDMHDD**.

3.3 Basic Organizational Requirements

3.3.1 Administrative Requirements

The **Contractor** shall provide to the TennCare Division of TDCI evidence of compliance with the following:

3.3.1.1 Provide to TDCI all documents and information listed in Tennessee Code Annotated §56-32-203(b) except the complaint procedure set forth in Tennessee Code Annotated §56-32-203(b)(11) must also comply with Section 3.5 of this CONTRACT.

3.3.1.2 Provide to TDCI full and complete disclosure of any financial interest held by an officer or a director of the BHO with any provider that may contract with the BHO.

3.3.1.3 Provide to TDCI for approval pro formas of all provider contracts, evidences of coverage under Tennessee Code Annotated, §56-32-207, and member handbooks the **Contractor** proposes to offer enrollees.**3.3.1.4** Provide to TDCI a description of the complaint and appeal system to be implemented by the **Contractor**, which must comply with Section 3.5 of this CONTRACT.

3.3.1.5 Agree to be covered and bound by Tennessee Code Annotated, § 56-32-206, with respect to Section 3.3.3 of this CONTRACT. However, should the **Contractor** be or become a licensed HMO in Tennessee, the **Contractor** must fully comply with Tennessee Code Annotated, §56-32-206.

3.3.1.6 Agree to be covered and bound by Tennessee Code Annotated, § 56-32-207.

3.3.1.7 Agree to be covered and bound by Tennessee Code Annotated, §56-32-209.

3.3.1.8 Agree to be covered and bound by Tennessee Code Annotated, §56-32-210, with respect to Section 3.5 of this CONTRACT. However, should the **Contractor** be or become a licensed HMO in Tennessee, the **Contractor** must fully comply with Tennessee Code Annotated §56-32-210.

3.3.1.9 Agree to be covered and bound by Tennessee Code Annotated, §56-32-211.

3.3.1.10 Agree to be covered and bound by Tennessee Code Annotated, §56-32-213.

3.3.1.11 Agree to be covered and bound by Tennessee Code Annotated, §56-32-222.

3.3.1.12 Provide to TDCI a detailed statement verifying the **Contractor** is financially responsible and may reasonably be expected to meet its obligations under this CONTRACT to **Participants** and to **Judicials**.

3.3.1.13 A **Contractor** shall also agree to file a notice with TDCI describing any material modification of the documents and information reported to TDCI regarding above Sections 3.3.1.1, 3.3.1.2, 3.3.1.3, 3.3.1.4 and 3.3.1.5. Such notice shall be filed with TDCI prior to any modification and, if TDCI does not disapprove of the modification within thirty (30) calendar days of filing, then the modification shall be deemed approved.

3.3.2 Financial Requirements

The **Contractor** must comply with the following financial requirements:

3.3.2.1 Establish and maintain a minimum net worth equal to the greater of (1) three million dollars ($3,000,000), or (2) an amount totaling five percent (5%) of the first one hundred fifty million dollars ($150,000,000) of the TennCare revenue earned by the **Contractor** under this CONTRACT for the prior calendar year, plus three percent (3%) of the TennCare revenue earned by the **Contractor** under this CONTRACT in excess of one hundred fifty million dollars ($150,000,000) for the prior calendar year. This net worth shall be determined by statutory accounting principles utilized by TDCI in regulating HMOs licensed in the State of Tennessee. Furthermore, in determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form

acceptable to TDCI. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses. The **Contractor** shall adhere to the aforementioned standards regarding net worth or net worth standards set forth by applicable law, whichever is less stringent.

3.3.2.2 Establish and maintain a positive working capital (current assets exceed current liabilities), which shall be determined by the use of statutory accounting principles utilized by TDCI in regulating HMOs licensed in Tennessee.

3.3.2.3 Establish and maintain a deposit of six hundred thousand dollars ($600,000), plus an additional deposit of two hundred thousand dollars ($200,000) for each twenty million dollars ($20,000,000) or fraction thereof of the TennCare revenue earned by the **Contractor** under this CONTRACT in excess of forty million dollars ($40,000,000) as reported on the most recent annual financial statement filed with the TennCare Division of TDCI and verified by TennCare. The deposit required to be maintained on any revenues earned under this CONTRACT in excess of forty million dollars shall be established and maintained within thirty (30) calendar days after the annual financial statement of the **Contractor** is due to be filed with the TennCare Division of TDCI. These deposits shall be maintained in a controlled custodial account with TDCI or with any trustee or organization acceptable to TDCI and shall consist of cash, securities, or any combination of these acceptable to TDCI. This deposit shall be considered an asset in calculating the **Contractor**'s minimum net worth outlined in Section 3.3.2.1. of this CONTRACT. In any year in which the accumulated deposit of the **Contractor** is more than the amount required to be maintained by the **Contractor** by the terms of this Section, at the **Contractor**'s request TDCI shall reduce the previous accumulated deposit by the amount the deposit exceeds the deposit required by this Section. This amount shall be used and shall be considered held in trust to protect the interests of the **Contractor**'s **Participants** and to ensure continuation of health care services to such Participants if the **Contractor** fails to perform its duties under this CONTRACT. If the **Contractor** is placed voluntarily in rehabilitation or liquidation, then the **Contractor** agrees this deposit shall immediately prior to the filing of the rehabilitation or liquidation proceeding vest in the State of Tennessee. The state shall then use its funds in this deposit to pay for the continuation of health care services to **Participants** and **Judicials** during the first one hundred eighty (180) days after the filing of the rehabilitation or liquidation, with any remaining amount distributed to pay first the costs of any state rehabilitation or liquidation proceeding and second the unsecured claims of **Participants**, **Judicials** and providers of the **Contractor** on a pro rata basis. The **Contractor** shall adhere to the aforementioned standards regarding deposit requirements or deposit requirements set forth by applicable law, whichever is more stringent.

3.3.3 Fidelity Bonds

The **Contractor** shall obtain the following fidelity bonds:

3.3.3.1 A fidelity bond on **Contractor** employees and officers in an amount of not less than $500,000.

3.3.3.2 Proof of coverage must be submitted to **TDMHDD** within sixty (60) calendar days after execution of this CONTRACT or prior to the delivery of health care, whichever comes first.

3.3.4 Insurance

The **Contractor** must procure adequate general liability, professional liability, and workers compensation insurance. For purposes of this CONTRACT, the amount of such liability insurance may not be less than one million dollars ($1,000,000) per individual and three million dollars ($3,000,000) in the aggregate. The **Contractor** must furnish proof of coverage of insurance to **TDMHDD** by Certificate of Insurance issued by the insurance carrier or one or more sureties licensed in the State of Tennessee.

TDMHDD shall be exempt from and in no way liable for any sums of money which may represent a deductible in any insurance policy. The payment of such a deductible is the sole responsibility of the **Contractor**.

3.3.5 Ownership and Financial Disclosure

The **Contractor** shall disclose to **TDMHDD**, the Comptroller General and/or HCFA full and complete information regarding ownership, financial transactions and persons convicted of any criminal activity. This disclosure shall be made at times and on forms prescribed by the **TDMHDD**. The following information shall be disclosed:

3.3.5.1 The name and address of each person with an ownership or controlling interest in the **Contractor**, sub**Contractor**, any provider, joint ventures, parent or subsidiary of **Contractor**.

3.3.5.2 The identity of any person who has an ownership or controlling interest, or is an officer or director of the **Contractor**, or is an agent or managing employee of the **Contractor** and who has been convicted of a criminal offense.

TDMHDD and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

3.4 Responsibilities Regarding Provision of Specific Services

3.4.1 Participant Identification Card

The **Contractor**, either alone or in conjunction with one or more TennCare MCOs, shall provide an identification card for **Participants** in the TennCare Partners Program. If the **Contractor** elects to provide this card separately from the MCO card, then the **Contractor** shall issue the card subject to prior approval of the format and content by TennCare or TDMHDD. All expenses associated with production and mailing of a separate identification card are the responsibility of the **Contractor**.

3.4.2 Explanation of Benefits to Participants

The **Contractor** must give a full written explanation of the **Contractor's** plan to **Participants** at the time they are enrolled in the **Contractor's** plan. This explanation must have written prior approval from **TDMHDD**. This written explanation must include, at a minimum, the following:

3.4.2.1 Effective date of enrollment;**3.4.2.2** Description of services provided including requirements, exclusions, and out-of-plan use;

3.4.2.3 Procedures for obtaining covered services;

3.4.2.4 **N**ames of providers and location of service sites (including telephone numbers and office hours);

3.4.2.5 Emergency services and procedures for obtaining emergency services both in and out of state;

3.4.2.6 Appeal procedures;

3.4.2.7 **Participant** rights/responsibilities (See Sections 2.3.3 and 2.5);

3.4.2.8 Written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436(d);

3.4.2.9 Notice to the **Participant** that enrollment in the **Contractor**'s plan invalidates any prior authorization for services granted by another plan but not used by the **Participant** before the **Participant's** enrollment into the **Contractor**'s plan;

3.4.2.10 The **Participant's** responsibility to notify the **Contractor** and TennCare within ten (10) days after the member moves to a new address;

3.4.2.11 The **Contractor**'s published toll-free telephone number which is answered by staff 24 hours a day, seven days a week, who are trained to respond to requests, concerns, and questions from **Participants** and their family members or legal representatives [the telephone must be answered daily in the Tennessee administrative office from 7:00 a.m. until 7:00 p.m. (Central time); after these peak hours, the telephone must be answered promptly, but can be routed to other locations]; this information must be accompanied by a statement that the **Participant** may contact the plan, **TDMHDD** or **TDMHDD'S** designee regarding questions about the TennCare Partners Program.

3.4.2.12 A fact sheet developed and approved by **TDMHDD** in accordance with Section 3.6.2.3.

3.4.3 Coordination of Services

3.4.3.1 The **Contractor** must assure active coordination between the following: mental health and substance abuse services; mental health care and primary health care; inpatient and outpatient care; and the child and adult mental health delivery system. This coordination must occur according to **TDMHDD** established guidelines for the following:

3.4.3.1.1 DCS for the purposes of providing covered mental health and substance abuse services to TennCare eligible children and youth in the custody of DCS in such a way as to facilitate the state's efforts to provide a full range of appropriate and effective services to these children and youth.

3.4.3.1.2 Tennessee Department of Health (DOH) for the purposes of establishing and maintaining relationships with **Participant** groups and providers of other health and substance abuse services.

3.4.3.1.3 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect.

3.4.3.1.4 TDFA TennCare, for the purposes of interfacing with and assuring continuity of care.

3.4.3.1.5 TennCare MCOs, for the purpose of coordinating care and compliance with the requirements of EPSDT.

3.4.3.1.6 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services for **Participants** in inpatient, residential, and day treatment mental health facilities, and compliance with the requirements of Individuals with Disabilities Education Act (IDEA).

3.4.3.1.7 Local law enforcement agencies and hospital emergency rooms for the purposes of Crisis Response Team relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

3.4.3.1.8 Civil, criminal, and juvenile courts for the purposes of fulfilling statutory requirements of Tennessee Code Annotated for mental health and substance abuse services referenced in Section 2.6.5.

3.4.3.1.9 State and Regional Mental Health Planning Committees for the purposes of providing information necessary for fulfilling the duties of the State and Regional Mental Health Planning Committees.

3.4.3.2 The **Contractor** must ensure coordination among providers with reference to each of the following:

3.4.3.2.1 Communication and coordination between mental health providers and substance abuse providers, including:

3.4.3.2.1.1 Assignment of a responsible party to assure communication and coordination occur;

3.4.3.2.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers;

3.4.3.2.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers;

3.4.3.2.1.4 Description of how service plans will be coordinated between mental health and substance abuse service providers;

3.4.3.2.1.5 Description of the provision of cross-training of mental health and substance abuse providers.

3.4.3.2.2 Smooth coordination between the children and adolescent service delivery system and the adult mental health service delivery system.

3.4.3.2.3 Coordination of inpatient and community services, including the following requirements related to hospital admission and discharge:

3.4.3.2.3.1 The outpatient provider must be involved in the admissions process when possible; if the outpatient provider is not involved, the provider must be notified promptly of the **Participant's** hospital admission;

3.4.3.2.3.2 Discharges cannot occur without a realistic discharge plan in which the **Participant** has participated (an outpatient visit must be scheduled before discharge which assures access to proper physician/medication follow-up; also, a housing site must be secured prior to discharge);

3.4.3.2.3.3 The mental health case manager must be involved in discharge planning; if there is no mental health case manager, then the outpatient provider must be involved; and

3.4.3.2.3.4 A procedure to assure continuity of care regarding medication;

3.4.3.2.3.5 The **Contractor** shall identify and develop community alternatives to inpatient hospitalization for those individuals who are receiving inpatient psychiatric facility services but who no longer require acute inpatient care and who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the **Contractor** does not provide appropriate community alternatives, the **Contractor** shall remain financially responsible for the continued inpatient care of these individuals. The **Contractor** shall provide quarterly summary reports on the use of these alternatives in a format to be prescribed by **TDMHDD**.

3.4.3.2.3.6 The **Contractor** shall have responsibility to provide a discharge plan as outlined above in Section 3.4.3.2.3. Liquidated Damages may be assessed in accordance with Section 5.3.3 when the **Contractor** fails to provide a written discharge plan or provides a defective discharge plan where a participant files a complaint after being discharged due to an inadequate discharge plan or where a participant appeals and the basis of the appeal is the discharge plan.

3.4.3.2.4 Coordination of physical health care and mental health care, including:

3.4.3.2.4.1 Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;

3.4.3.2.4.2 Means for the transfer of information (to include items before and after the visit);

3.4.3.2.4.3 Maintenance of confidentiality; and

3.4.3.2.4.4 A description of the types of training activities to be provided and a schedule of training activities. At a minimum, information must be provided to primary health care providers on a quarterly basis; **Participants**, families, and providers of mental health and substance abuse services must be involved in at least two of the training activities yearly.

3.4.3.3 The **Contractor** shall coordinate treatment of **Participants** enrolled in the TennCare Partners Program with the TennCare MCOs, and such coordination shall include but not be limited to the following:

3.4.3.3.1 When disputes arise between the **Participant's** MCO and his or her BHO regarding responsibility for a particular medically necessary covered service, the BHO and the MCO shall coordinate to insure the service will be delivered to the **Participant** and the MCO and the BHO must split the cost of the service pending resolution of any dispute between the BHO and the MCO. The "cost" of the service shall be the greater of (1) the cost if the MCO were responsible for providing the service or (2) the cost if the BHO were responsible for providing the service**.** Services to the **Participant** must not be delayed due to a party dispute between the MCO and BHO over the responsible for delivering the service. The **Participant's** MCO and his or her BHO are jointly responsible for the **Participant,** and the state will hold the MCO and the BHO jointly accountable for the quality of care the **Participant** receives.

3.4.3.3.2 Unresolved disputes between MCOs and BHOs shall be referred to the state or its designee for a decision on responsibility after the service has been delivered. Resolution of the disputes shall be governed by the following:

3.4.3.3.2.1 Either the MCO or the BHO may submit to the state a Request for Resolution regarding any dispute regarding payment for services under this provision. The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party.

3.4.3.3.2.2 The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the state shall be deemed a waiver of any objections to the Request for Resolution.

3.4.3.3.2.3 The state, or its designee, shall render a written decision to both the MCO and BHO regarding the entity responsible for the payment of services within 30 calendar days of receipt of the Response to the Request for Resolution.

3.4.3.3.2.4 Within five (5) working days of receipt of the decision, the non-successful party shall reimburse any payments made by the successful party for the service together with interest on the payments at any lawful rate designated by the state. Interest shall begin to accrue from the date the service was delivered.

3.4.3.3.2.5 The non-successful party shall also pay to the state, within thirty (30) calendar days of the decision, administrative costs for the dispute resolution as estimated by the state. The amount of the estimated cost shall be contained within the state's decision.

3.4.3.3.2.6 The obligations of the non-successful party to pay the amount specified in this provision are absolute and may not be withheld pending resolution of any court of competent jurisdiction. However, these payments may be made with reservation of rights regarding any such judicial resolution.

3.4.3.3.2.7 If a party fails to pay the state for the administrative costs as described in Subsection 3.4.3.3.2.5 within thirty (30) calendar days, the state may deduct its amounts from any current or future amount owed the party.

3.4.3.3.2.8 Appeal of any decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq.

3.4.3.3.2.9 Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.

3.4.3.3.3 Services to Prevent Children From Entering State Custody

The **Contractor** shall have a responsibility to promptly provide all covered services required by a **Participant** under the age of 18 enrolled in the C**ontractor**'s plan. TennCare may assess liquidated damages in accordance with Section 5.3.3 from the date of entry into state custody where:

3,4.3.3.3.1. The **Contractor** has notice an individual under 18 is in need of a covered medically necessary service; and

3.4.3.3.3.2. The service is ordered and requested of the **Contractor** by the treating physician; and

3.4.3.3.3.3. The **Contractor** fails to provide an appropriate medically necessary service in the least restrictive setting; and

3.4.3.3.3.4 These circumstances result in the child entering state custody.

3.4.4 Cost-Sharing for Services

There are no cost-sharing requirements for Medicaid-eligible persons enrolled in the Tenncare Partners Program. There are also no cost-sharing requirements for non-TennCare eligible receiving judicial services.

Cost sharing for services in the TennCare Partners Program applies only to persons identified by TennCare as not Medicaid-eligible and as having incomes greater than 100% poverty. Cost-sharing requirements for these persons in the TennCare Partners Program shall be consistent with the cost-sharing guidelines as described in TennCare Rule 1200-13-12-.05 of TDFA.

3.4.5 Continuity of Care

The **Contractor** must provide a smooth transition of **Participants** in the TennCare Partners Program from one provider to another when there are changes in providers. The **Contractor** shall have in place transition policies which have been approved by **TDMHDD**. At a minimum, the following items will be included:

3.4.5.1 A schedule which assures transfer does not create a lapse in service;

3.4.5.2 A mechanism for timely information exchange (including transfer of the **Participant** record);

3.4.5.3 A mechanism for assuring confidentiality;

3.4.5.4 A mechanism for allowing a **Participant** to request and be granted a change of provider;

3.4.5.5 A requirement that proper and timely notice be given to the **Participant** which includes an explanation of why the current provider is no longer available, a listing of new providers and how to contact them, the procedure the **Participant** needs to follow in order to change providers, and the effective date of change;

3.4.5.6 A requirement that proper and timely notice be given to the current provider so proper termination can occur between the **Participant** and provider;

3.4.5.7 For individuals in transition to new providers in the TennCare Partners Program, reference to the following:

3.4.5.7.1 Development of a termination plan which addresses the clinical and interpersonal dynamics of the relationship the individual has with the current provider and how a new relationship will be developed with the new provider; and

3.4.5.7.2 Establishment of a schedule which allows for appropriate termination from the present provider (including **Participant** involvement in establishing the schedule);

3.4.5.7.3 **For members of the Priority Population**, the policies and procedures must reflect an appropriate schedule as approved by **TDMHDD** for transitioning the a **Participant** from one provider to another when there is medical necessity for ongoing care. Because persons in the **Priority Population** are at risk for experiencing setbacks in their care when their providers are changed, the **Contractor** shall insure that **Priority Participants** are allowed to remain with their providers of the services listed below for the minimum timeframes set out below as long as the services continue to be medically necessary. For an inpatient stay, as an example, this Subsection is applicable only if the person continues to require inpatient psychiatric facility care six months after the initiation of the CONTRACT. The **Contractor** may shorten these transition timeframes only when the provider of services is no longer available to serve the **Priority Participant** or when a change in providers is agreed to in writing by the **Priority Participant.**

Service	**Minimum time required before a transition in providers is made at the initiation of the CONTRACT**
Mental Health Case Management	3 months
Psychiatrist	3 months
Outpatient therapy	3 months
Psychosocial rehabilitation; supported employment	3 months
Inpatient or residential treatment; supportive housing	6 months

3.4.6 Out-of- State and Out-of-Plan Use

The **Contractor** must notify and advise all TennCare Partners Program **Participants** of the provisions governing out of plan use, including the use of providers outside the state. The following criteria shall apply:

3.4.6.1 The **Contractor**'s plan must include provisions governing utilization of and payment by the **Contractor** for covered emergency services received by a **Participant** from non-contract providers, regardless of whether such covered emergency services are rendered within or outside the state. Provision of covered emergency services shall not be subject to prior authorization by the **Contractor** but may include a requirement that notice be given to the **Contractor** of use of out-of-plan covered emergency services; such notice requirement shall provide at least a twenty-four (24) hour time frame after the performance of the covered service for notice to be given. Utilization of and payments to non-contract

providers may, at the **Contractor**'s option, be limited to the treatment of covered services rendered to the **Participant** until such time as he/she can be safely transported to an appropriate contract service provider location. Payment amounts shall be consistent with the pricing policies developed by the **Contractor** for covered services. Payment by the **Contractor** for properly documented claims for covered services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the **Contractor**.

3.4.6.2 The **Contractor** must review and approve or disapprove claims for covered emergency services based on the definition of covered services referenced in Attachment A, Attachment B, the prudent layperson standard and contractual terms found in Section 3.4.10 of this CONTRACT. If a provider disagrees with the **Contractor**'s decision to disapprove a claim for covered emergency services, the provider may request an informal review by TennCare after having exhausted all steps in the **Contractor**'s plan for the resolution of such disputes. As the result of the informal review, if TennCare determines the claim should be allowed, the **Contractor** shall make payment for the claim. After informal review, if TennCare determines the **Contractor**'s denial was correct, the provider shall have the right to request a formal hearing, pursuant to Tennessee Code Annotated, §71-5-113, on the matter within thirty (30) calendar days of the decision. All requests for a formal hearing from providers for covered emergency service claims denied by the **Contractor** must be submitted in writing to TennCare for review and final determination. TennCare's decision in such matters shall not be rendered arbitrarily but shall be based upon the facts at hand and the applicability of the various requirements of this CONTRACT. The **Contractor** agrees to pay previously denied covered emergency service claims if the decision by TennCare is to honor the claim.

3.4.6.3 The **Contractor** must include provisions governing the referral and payment for covered services provided to a **Participant** by a non-contract provider at the request of a contract provider. The **Contractor** must require the out-of-plan provider to accept the **Contractor** payment, plus applicable copayments and special fees, as payment in full for the service(s) by regulation in accordance with TennCare Rule 1200-13-12-.08(1) of TDFA.

3.4.6.4 When a **Participant** has used non-emergency covered services available under this CONTRACT from a provider who was not enrolled as a participating provider in the **Contractor's** provider network and the **Contractor** has not authorized such use in advance, the **Contractor** may, at its option, choose to pay or not pay for the service(s) received. The **Contractor** must require the out-of-plan provider to accept the **Contractor** payment as payment in full for the service(s) in accordance with TennCare Rule 1200-13-12-.08(1) of TDFA.

3.4.6.5 The **Contractor** shall not make payment to non-participating providers for non-covered services.

3.4.6.6 When a **Participant** is dually eligible for Medicare and Medicaid and requires services covered by the TennCare Partners Program but not covered by Medicare, and the services are ordered by a physician who accepts Medicare payment and is a non-contract provider with the **Contractor,** the plan must provide reimbursement for the ordered service if the service is provided by a contract provider. Reimbursement must be at the same rate paid had the service been ordered by a contract provider.

3.4.6.7 The **Contractor** is not liable for the cost of non-covered services or the cost of services ordered and obtained from non-contract providers.

3.4.6.8 No **Contractor** shall regularly make reimbursement payments to non-contract providers for non-emergency services without subjecting those providers to the same credentialing and approval process required by **TDMHDD** for contract providers. The term "regularly" means no more than ten (10) such payments to any non-contract provider for non-emergency services over any continuous twelve (12) month period. Any non-contract provider "regularly" providing non-emergency services must be credentialed and recredentialed by the **Contractor** in accordance with Section 3.8 within thirty (30) calendar days after the event occurs requiring such approval.

3.4.6.9 Non-contract providers who regularly receive payments from the **Contractor** need not sign a contract with the **Contractor.** However, if non-contract providers regularly used by the **Contractor** are not credentialed as provided in Subsection 3.4.6.7, then the **Contractor** shall make no further payments to them.

3.4.7 Advance Directives

The **Contractor** shall comply with federal requirements concerning advance directives as described in 42 CFR 417.436 and 489 Subpart I, and as described in Tennessee Code Annotated, §§32-11-105, 34-6-201 through 34-6-215, and 68-11-201 through 68-11-224, and as stipulated by the **Participant**.

3.4.8 Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires all laboratory testing sites have either a CLIA certificate of waiver or a CLIA certificate of registration to legally perform testing in the United States.

The Contractor shall require all laboratory testing sites providing services under this CONTRACT have either a (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The Contractor shall comply with the provisions of CLIA 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA.

3.4.9 Acceptance of Participants from Failed BHO Plans

The **Contractor** must agree to accept a reasonable number of **Participants** from any failed BHO plan, including any plan which is terminated in whole or in part, may become insolvent, or discontinues service in an area for any reason. The term "reasonable", subject to the discretion of **TDMHDD**, means at a minimum the total number of **Participants** from a failed BHO plan divided by the number of remaining BHOs in the TennCare Partners Program. The transfer of membership may occur at any time during the calendar year. All transferred **Participants** must receive the same benefit package they would have received had they been assigned to the **Contractor**'s plan initially. Monthly capitation rates for transferred **Participants** must be the same as paid to the **Contractor** for other **Participants** enrolled in the **Contractor**'s plan. No **Participant** from a failed BHO plan shall be transferred retroactively to the **Contractor**'s plan. For purposes of this requirement, the **Contractor** is not responsible for any mental health and

substance abuse services incurred by such **Participants** before the effective date of transfer to the **Contractor**'s plan.

3.4.10 Emergency Mental Health and Substance Abuse Treatment Services

3.4.10.1 The **Contractor** shall provide coverage for inpatient and outpatient mental health and substance abuse treatment services, furnished by a qualified provider, needed to evaluate or stabilize an emergency medical condition found to exist using the prudent layperson standard. Regulation 422.2 of the Code of Federal Regulations places prudent layperson within the definition of emergency medical condition as follows: "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. This entire definition should be considered when making a determination of whether a **Participant** acted appropriately in seeking emergency care. Once the individual's condition is stabilized, the **Contractor** may require authorization for inpatient admission or follow-up care. The **Contractor** shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgement of a prudent layperson. The **Contractor** shall impose no restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard.

3.4.10.2 If an emergency screening examination leads to a clinical determination by the examining mental health or substance abuse treatment professional that an actual emergency medical condition exists, the **Contractor** shall pay for both the services involved in the screening examination and the services required to stabilize the enrollee. The **Contractor** shall be required to pay for all mental health and substance abuse treatment related emergency services which are medically necessary until the clinical emergency is stabilized. This includes all mental health and substance abuse treatment services necessary to assure, within reasonable medical probability, no material deterioration of the enrollee's condition is likely to result from, or occur during, discharge of the enrollee or transfer of the enrollee to another facility. If there is a disagreement between the hospital and the **Contractor** concerning whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on the **Contractor**. The **Contractor**, however, may establish arrangements with a hospital whereby the **Contractor** may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the enrollee, provided that such arrangement does not delay the provision of emergency mental health or substance abuse treatment services.

3.4.10.3 The **Contractor** shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical

condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the enrollee had acute symptoms of sufficient severity at the time of presentation. In such cases, the **Contractor** shall review the presenting symptoms of the enrollee and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

3.4.10.4 When a **Participant's** primary care provider instructs the **Participant** to seek emergency mental health or substance abuse treatment services, the **Contractor** shall be responsible for payment for the medical screening examination and for other medically necessary emergency mental health and substance abuse treatment services, without regard to whether the enrollee meets the prudent layperson standard.

3.4.10.5 In accordance with the Balanced Budget Act of 1997, the **Contractor** shall cover the following services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the **Contractor**'s provider network:

- Post-stabilization care services pre-approved by the **Contractor**; or
- Post-stabilization care services not pre-approved by the **Contractor** because the **Contractor** did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care, or could not be contacted for pre-approval.

The **Contractor** can choose not to cover post-stabilization care services out-of-network except in the above stated circumstances.

3.5. Complaint and Appeal System Requirements

The **Participant** shall have the right to file complaints or appeals regarding actions taken by the **Contractor** to deny, reduce, terminate or suspend a covered service ordered or prescribed by a participating provider. For purposes of this requirement, appeal shall mean a **Participant's** right to contest in writing, any action taken by the **Contractor** to deny, reduce, terminate or suspend a covered service ordered or prescribed by a participating provider. Complaint shall mean a **Participant's** right to contest any other action taken by the Contractor or service provider other than denial, reduction, termination or suspension of a covered service and shall also include omission (e.g., failure to act) by the **Contractor**. The **Contractor** shall provide readable materials reviewed and approved by TDMHDD and TennCare informing **Participants** of their complaint and appeal rights. The **Contractor** shall develop internal complaint and appeal procedures in accordance with TennCare Rule 1200-13-12-.11 of TDFA or any subsequent amendments.

The **Contractor** shall have responsibility to provide written notice to **Participants** of any action to deny, reduce, terminate, suspend, or delay covered services. Liquidated damages may be assessed in accordance with Section 5.3.3 when the **Contractor** fails to provide written notice or provides defective notice of these

actions as identified by TennCare or the Appeals Unit in the context of an appeal or complaint made on behalf of a **Participant.**

A portion of the regularly scheduled Quality Improvement meetings shall be devoted to the review of enrollee complaints and appeals that have been received and resolved. The complaint and appeal procedures shall be governed by the following guidelines which are in accordance with TennCare rule 1200-13-12-.11:

3.5.1 Appeals

Appeal shall mean a Participant's right to contest in writing, any action taken by the **Contractor** to deny, reduce, terminate or suspend a covered service ordered or prescribed by a participating provider.

3.5.1.1 The **Contractor** shall have a contact person appointed at each service site. Said person will direct all appeals to be filed via mail to the designated P. O. Box for appeals related to the **Contractor**;

3.5.1.2 There shall be sufficient support staff (clerical and professional) available to process appeals in the manner specified in TennCare Rule 1200-13-12-.11 related to the Appeal of Adverse Actions Affecting a TennCare or TennCare Partners Program Enrollee;

3.5.1.3 Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the time frames in which action must be taken by the **Contractor** regarding the handling and disposition of an appeal;

3.5.1. The appropriate individual or body within the plan authorized to approve or deny appeals shall be identified;

3.5.1.5 Appeal forms shall be made available at each service site and by contacting the **Contractor**. However, **Participants** shall not be required to use an appeal form in order to file an appeal;

3.5.1.6 Upon request, the enrollee shall be provided a TennCare Partners Program approved appeal form(s);

3.5.1.7 All appellants shall have the right to reasonable assistance by the **Contractor** during the appeal process;

3.5.1.8 Appeals shall be processed in accordance with TennCare Rule 1200-13-12-.11 or TDFA related to the Appeal of Adverse Actions Affecting a TennCare Program Enrollee. These regulations set forth the time frames and processes that must be utilized in the appeal process. The decision of the **Contractor** shall be in writing and include a description of the appeal, the basis for the decision and identification of any documents reviewed and relied upon in the appeal decision;

3.5.1.9 Reports of appeals and resolutions shall be submitted monthly to TDMHDD and TennCare in such format and manner as determined by TennCare;

3.5.1.10 If the **Participant** is not satisfied with the decision of the **Contractor**, the **Participant** may file an appeal contesting the **Contractor**'s decision as set out in the rules and regulations of TennCare for appeal of adverse decisions affecting a **Participant** in the Tenncare Partners Program. The **Contractor** shall provide to TennCare Partners Program the information and materials relied upon in the reconsideration/denial, and as required by the TennCare Rule 1200-13-12-.11;

3.5.1.11 The state level review will be conducted in accordance with the Tenncare rules and regulations. The **Contractor** is bound by the results of the state level decision;

3.5.1.12 At any point in the appeal process, TennCare shall have the authority to remove a **Participant** from the Contractor's plan when it is determined such removal is in the best interest of the **Participant** and TennCare; and

3.5.1.13 TennCare may develop additional appeal process guidelines or rules, which shall be followed by the **Contractor**, if TennCare determines it is in the best interest of the TennCare Partners Program and the addition is necessary to comply with federal or judicial requirements.

3.5.2 Complaints

Complaint shall mean a **Participant's** right to contest any other action taken by the **Contractor** or service provider other than the denial, reduction, termination or suspension of a covered service.

3.5.2.1 The **Contractor** shall have a contact person appointed at each service site. Said person will direct all complaints to the complaint coordinator at **Contractor**'s corporate office;

3.5.2.2 There shall be sufficient support staff (clerical and professional) available to process complaints;

3.5.2.3 Staff shall be educated concerning the importance of the procedure and the rights the enrollee;

3.5.2.4 The appropriate individual or body within the plan authorized to approve or deny complaints shall be identified;

3.5.2.5 Complaint forms shall be made available at each service site and by contacting the **Contractor**;

3.5.2.6 All persons filing complaints shall have the right to reasonable assistance by the **Contractor** during the **Contractor**'s complaint process;

3.5.2.7 Complaints shall be resolved within thirty (30) calendar days from the initial filing of the complaint document by the **Participant**. The decision of the **Contractor** shall be in writing and include a description of the complaint, the basis for the decision and identification of any documents reviewed and relied upon in the complaint decision;

3.5.2.8 Reports of complaints and resolutions shall be submitted monthly to TennCare in such format and manner as determined by TennCare; and

3.5.2.9 At any point in the complaint process, TennCare shall have the authority to intercede in the process when it is determined that such intervention is in the best interests of the **Participant** and TennCare and necessary to comply with federal or judicial requirements.

If it is determined by TennCare that violations regarding the appeal guidelines have occurred by the **Contractor**, TennCare shall require the **Contractor** submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TennCare, including an acceptable corrective action plan, shall result in the **Contractor** being subject to liquidated damages as described in Section 5.3.3 of this CONTRACT.

The **Contractor** shall be prohibited from taking any adverse action against a participating provider as the result of the provider assisting a **Participant** in the appeals process required pursuant to this contract and the TennCare rules when the provider believes in his or her professional opinion the **Contractor's** denial, reduction, termination, suspension or delay in covering the service will adversely affect the **Participant's** health.

3.5.3 Other Appeals

The TennCare Rules describe certain appeal procedures that may not relate to BHOs and should be addressed directly to TennCare. The following procedures have been provided below for informational purposes in an effort to disclose other types of appeals.

3.5.3.1 Medicaid-certified enrollees or Medicaid applicants have the right to appeal denials of Medicaid eligibility and termination of eligibility decisions to the Department of Human Services, in accordance with the provisions of Official Compilation Rules and Regulations of the State of Tennessee Chapter 1240-5-3 and the provisions and criteria set out in this chapter, as applicable.

3.5.3.2 Enrollees applying for Seriously and Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) determination shall apply for each determination to TDMHDD or its successor. SPMI and SED determinations shall be grieved in accordance with the provisions and criteria of federal and state law, as applicable.

3.5.3.3 If it is determined by TennCare that violations regarding the appeal guidelines have occurred by the **Contractor,** TennCare shall require that the **Contractor** submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TennCare, including an acceptable corrective action plan, shall result in the Contractor being subject to liquidated damages as described in Attachment E.

3.6 Marketing

3.6.1 Marketing materials include any items or techniques used to communicate with or educate **Participants** or potential **Participants.** All marketing materials must be approved in writing by **TDMHDD** before use. The **Contractor** must submit to **TDMHDD** all draft marketing materials including, but not limited to, the following: brochures, posters, fact sheets, billboard ads, magazine and/or newspaper ads and other forms of commercial advertising, newsletters, health fair displays, etc. **TDMHDD** shall review the materials and either approve or deny the materials (with written comments) within fifteen (15) calendar days from the date of submission. Failure to comply with

the marketing limitations contained in this CONTRACT may result in the imposition by **TDMHDD** of one or more of the following sanctions, which shall remain in effect until **TDMHDD** determines the deficiency has been corrected:

3.6.1.1 Revocation of previously authorized marketing methods;

3.6.1.2 Refusal of new assignments of **Participants** to the **Contractor**'s plan, for a period of time to be determined by **TDMHDD**;

3.6.1.3 Requirement that the **Contractor** personally contact each **Participant** who is affected during the period of time while the **Contractor** was out of compliance, in order to explain the nature of the noncompliance and inform the **Participant** of his or her right to disenroll; and

3.6.1.4 Application of liquidated damages as provided in Section 5.3.3 of this CONTRACT.

3.6.2 All services listed in the marketing materials must be provided as described. The **Contractor** must adhere to all requirements developed by TennCare including, but not limited to, the following:

3.6.2.1 The **Contractor** must not engage in marketing practices that mislead, confuse, or defraud.

3.6.2.2 The **Contractor** must not engage in unfair or deceptive marketing practices or otherwise violate federal or state consumer protection laws or rules.

3.6.2.3 The **Contractor** must assist with the development of a fact sheet providing quality and cost information related to the **Contractor**'s plan developed under this CONTRACT. This fact sheet must be available to all **Participants** and prospective **Participants.**

3.6.2.4 The **Contractor** must not implement and/or use any marketing plan, procedure, and/or materials developed under this CONTRACT until approved in writing by **TDMHDD** as described in this Section.

3.6.2.5 All terms, conditions, and policies stated above apply to staff, agents, officers, sub**Contractor**s, providers, volunteers, and anyone acting for or on behalf of the **Contractor**.

3.7 Staff Requirements

3.7.1 General Requirements

The **Contractor** must maintain a sufficiently staffed and working office within the state of Tennessee, including a full-time Tennessee-based administration specifically identified to conduct the day-to-day business and programmatic activities of this CONTRACT.

At a minimum, the **Contractor** must employ in its Tennessee office the following: director of operations, director of finance, medical director, quality improvement director, **Participant** advocate, care managers, and customer service representatives;

Staffing for seven regional offices must meet the minimum requirements of Section 3.8.5.2.1.

3.7.2 Training

The **Contractor** must participate in training to include, but not be limited to, judicials, forensics, crisis, mandatory prescreening, TPG and CRG assessments, substance abuse, mental health case management, and other areas specified in Standard IX of the BHO Quality Monitoring Program (QMP) Standards (see Attachment C), as required by **TDMHDD**.

3.7.3 Telephone Access for Participants and Providers

3.7.3.1 The **Contractor** must provide a published toll-free telephone number that is answered in the **Contractor**'s Tennessee administration office by staff who are trained to respond to requests, concerns, and questions from **Participants**, family members, and providers. Staff must be available to answer telephone calls from 7:00 a.m. Central time until 7:00 p.m. Central time seven days a week. After these peak hours, calls must be answered promptly, but can be routed to other locations.

3.7.3.2 **Contractor** must provide procedures to insure all **Participants** and network providers receive the above telephone number, including publishing the number in member handbooks as specified in Section 3.4.2 and in newsletters as referenced in Section 3.6.

3.7.3.3 The **Contractor** must also participate in the implementation of a toll-free crisis line for the general Tennessee population, as described in Section 2.6.5.

3.8 Provider Requirements

3.8.1 Licensure of Provider Sites

The **Contractor** must ensure each provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/ designation/ approval per **TDMHDD** requirements.

3.8.2 Licensure of Provider Staff

The **Contractor** must determine that all providers in its network maintain a current license or certification for the provision of those services as appropriate and must monitor the accuracy of the providers' current license or certification per **TDMHDD** requirements. The **Contractor** must further require non-participation of providers convicted of criminal activity, or otherwise not in good standing with TennCare or **TDMHDD**.

3.8.3 The **Contractor** will participate in the development and implementation of a centralized TennCare database to expedite the credentialing of providers in accordance with National Committee for Quality Assurance (NCQA) standards. Use of this database is mandatory for the **Contractor** within sixty (60) days of written notification by TennCare. The goal of the database will be to minimize repetitive requests to providers for the same primary and secondary source information during the credentialing and recredentialing process.

3.8.4 Credentialing Manual

The **Contractor** must maintain a current credentialing manual per **TDMHDD** requirements as set forth in Standard VIII of the BHO QMP Standards (see Attachment C). The manual must include at least the following components:

3.8.4.1 Policy, process and procedures for credentialing and privileging (initially and on an ongoing basis) individual clinical staff (including, at a minimum, psychiatrists, other physicians, psychologists, social workers, and nurses);

3.8.4.2 Policy, process and procedures for credentialing and recredentialing organizations providing mental health and substance abuse services as part of the provider network;

3.8.4.3 Appeal process for individual clinicians who are denied credentials or for whom sanctions are imposed; and

3.8.4.4 **A**ppeals process for network providers who are dropped from the network or for whom sanctions are imposed.

3.8.5 Provider Relations Plan

3.8.5.1 The **Contractor** must develop a Provider Relations Handbook for its network providers in the TennCare Partners Program.

3.8.5.2 The **Contractor** must implement a Provider Relations Plan, to be approved by **TDMHDD**. This plan must contain at least the following:

3.8.5.2.1 The full time employment of at least seven Tennessee-based provider relations specialists (one located in each of the seven designated mental health planning regions) who are available to providers at least Monday through Friday (excluding holidays), 8:00 a.m. to 5:00 p.m. Central time;

3.8.5.2.2 The establishment of a published 24-hour a day, seven days a week telephone number available only to network providers which offers provider assistance, including service authorization, clinical consultation, issue resolution, and information; the telephone must be answered on all business days in the Tennessee administrative office from 7:00 a.m. until 7:00 p.m. (Central time); after these peak hours, the telephone must be answered promptly, but can be routed to other locations;

3.8.5.2.3 An educational plan for network providers which includes, at least, **Contractor** requirements and topical information and which includes **Participants** and family members as trainers;

3.8.5.2.4 An annual provider satisfaction survey conducted with any necessary incentives to insure a minimum response rate of 70% of the **Contractor's** providers; a plan for addressing and resolving problems which are identified by the survey process; and a means for reporting survey results and related plans of correction and/or results of plans of correction to **TDMHDD** on an annual basis; and

3.8.5.2.5 A plan for networking activities for providers within the same geographic region; at a minimum, there must be quarterly network meetings for the following types of providers: mental health case managers, crisis service providers, housing/residential care service providers, psychiatric rehabilitation service providers, and substance abuse treatment providers.

3.8.6 Provider Networks

The **Contractor** shall provide the following information for **TDMHDD**'s approval:

3.8.6.1 A complete and accurate listing of all network providers who will be providing services in the Tenncare Partners Program under the **Contractor's** plan by CHA region. This information is to be submitted as prescribed by **TDMHDD**. The **Contractor** must include in this listing the specific number of staff persons who are providing services. This information must be updated monthly by the **Contractor**, with updates submitted as prescribed by **TDMHDD**. These updates are due at **TDMHDD** by the first day of each month. Failure of the **Contractor** to provide approvable monthly updates or to maintain a full and complete provider network which provides all covered services and meets all **TDMHDD** access and availability requirements may subject the **Contractor** to liquidated damages as described in Section 5.3.3 and Attachment E.

3.8.6.2 A statement documenting each facility/individual listed in response to Section 3.8.7.1 is properly licensed, certified, accredited, designated, approved, and/or meets required standards for the provision of those services which require certain licensure, certification, accreditation, approval, and/or compliance with standards.

3.8.6.3 The policies and procedures the **Contractor** will follow for monitoring the accuracy of the listing mentioned in Section 3.8.6.1. Included in the policies and procedures are:

3.8.6.3.1 Identification of which providers are required to be licensed, certified, accredited, approved, and/or meet **TDMHDD** standards;

3.8.6.3.2 A requirement for all providers to maintain their license, certification, accreditation, and/or approval verification on-site and at the Contractor's central office;

3.8.6.3.3 A description of the **Contractor**'s related monitoring activities which includes at least monthly reviews of provider licensure and certification by the **Contractor**; and

3.8.6.3.4 A requirement that **TDMHDD** be notified of changes, using the format prescribed by **TDMHDD**.

3.8.7 Letters of Referral

The **Contractor** shall provide to **TDMHDD** acceptable letters of referral with non-network mental health and substance abuse providers who are under contract to **TDMHDD** at the time this CONTRACT begins. These letters are required except in circumstances where the **Contractor** can document a good faith effort was made and the particular provider was unwilling to enter into a letter of referral.

There is no requirement to contract with **TDMHDD** providers. However, a mechanism must exist for referring Participants and Judicials identified in 2.6.5 between the **Contractor** and identified providers. Each letter of referral must:

3.8.71 Reflect a referral-based relationship between the **Contractor** and the provider;

3.8.7.2 Have a referral term of no less than one year from effective date of the agreement and contain language related to provisions for renewal;

3.8.7.3 Have a signature page which contains the **Contractor** representative's signature, the provider representative's signature, the typed names of each and their titles, the typed name of the provider, and the dates of signature;

3.8.74 Contain a description of the specific services being offered by the provider;

3.8.7.5 Be developed with each provider identified by **TDMHDD**.

3.8.8 Use of Hospital Providers and Safety Net Providers

3.8.8.1 Hospital Providers

The **Contractor** shall maintain a sufficient network of hospital providers with the capability of providing the benefits required under this CONTRACT to all eligible individuals as described in Section 2.2 of this CONTRACT. The **Contractor** shall maintain a sufficient inpatient provider network, so no inpatient provider, especially the regional mental health institutes, are forced to exceed their licensed capacity. In the event the **Contractor** terminates an arrangement with a hospital provider, the **Contractor** shall continue to provide care for all eligible individuals who are receiving care from that hospital provider at the time of termination until such time as the **Contractor** can reasonably transfer the enrollee to a service and/or network provider without interrupting service delivery.

3.8.8.2 Safety Net Providers

The **Contractor** is encouraged, to the extent possible and practical, to contract for the provision of mental health and substance abuse services with the Community Mental Health Centers (CMHCs) and Mental Health Case Management Agencies (CMHCMA) designated by **TDMHDD** for the provision of mental health services in the community and with substance abuse providers under contract with DOH. Where these safety net providers are not used, the **Contractor** must demonstrate to the satisfaction of **TDMHDD** that both adequate capacity and an appropriate range of services exist to serve the expected enrollment in each service area.

3.9 Requirements Regarding Contracts and Subcontracts

3.9.1 Subcontracts

The **Contractor** shall provide or assure the provision of all covered services specified under this CONTRACT. Any proposed subcontracts the **Contractor** wishes to enter into for performance of any of the work required under this CONTRACT must be submitted to **TennCare** for prior written approval. No proposed subcontract of the **Contractor**, which provides for the direct or indirect provision of covered services to a **Participant**, shall be approved if that subcontract requires the sub**Contractor** to assume financial risk that is not related to services either directly or indirectly furnished by that sub**Contractor** to **Participants** in the TennCare Partners Program. The term "indirectly" shall have the same meaning as set forth in Section 3.9.2.44 below.

No work shall commence under any subcontract between the **Contractor** and a potential sub**Contractor** without the written approval of TennCare. Provider contracts developed by sub**Contractor**s must meet all the conditions set out in the following Section and Section 3.3.1.3 of this CONTRACT.

3.9.2 Provider Contracts

The **Contractor** shall provide or assure the provision of all covered services specified under this CONTRACT. The **Contractor** may provide these services directly or may enter into contracts with qualified providers who will provide services to the **Participants** in exchange for payment by the **Contractor** for services rendered.

All provider contracts and amendments thereto must contain all the elements identified below. The **Contractor** shall not execute provider contracts with providers who have been convicted of criminal activity or who are otherwise not in good standing with the TennCare Program and **TDMHDD.**

All provider contracts executed by the **Contractor** under this Section shall, at a minimum, meet the following requirements and no other terms or conditions agreed to by the **Contractor** and provider shall negate or supersede the following requirements:

3.9.2.1 Be in writing;

3.9.2.2 Specify the effective dates of the provider contract with a term of no less than one (1) year and renewal options (cancellation clauses must be no less than 60 days);

3.9.2.3 Specify within in the provider contract that the provider contract and its attachments contain all the terms and conditions agreed upon by the parties;

3.9.2.4 Require the provider not to enter into any subsequent contracts or subcontracts for any of the work contemplated under the provider contract without approval of the **Contractor**;

3.9.2.5 Identify all populations covered by the provider contract, especially those populations covered under the TennCare Program and the TennCare Partners Program;

3.9.2.6 Specify the provider may not refuse to provide medically necessary covered services to a TennCare Partners Program **Participant** covered under this CONTRACT for non-medical reasons or for failure to pay applicable co-payments, or special fees. In accordance with Section 3.4.4.1, the provider may not charge **Participants** for missed appointments unless otherwise approved by TennCare or **TDMHDD**. The provider shall not be required to accept or continue treatment of a **Participant** with whom the provider, in good faith, determines he/she cannot establish and/or maintain a professional relationship;

3.9.2.7 Specify the functions and/or services the provider and determine the functions and/or services to be provided are within the scope of his/her professional/ technical practice;

3.9.2.8 Specify the amount, duration and specific services required of the provider;

3.9.2.9 Provide emergency services be rendered without the requirement of prior authorization of any kind;

3.9.2.10 If the provider performs laboratory services, the provider must meet all applicable requirements of CLIA of 1988 at such time HCFA mandates the enforcement of the provisions of CLIA, as stated in Section 3.4.8.

3.9.2.11 Require an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to **Participants** pursuant to the CONTRACT (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider contract). **Participants** and their representatives shall be given access to the **Participant's** medical records, to the extent and in the manner provided by Tennessee Code Annotated, §§33-3-104(10), 63-2-101(a) & (b) and 63- 2-102, 42 CFR 2, and subject to reasonable charges, be given copies thereof upon request;

3.9.2.12 Require any and all records be maintained for a period not less than five (5) years from the close of the CONTRACT and retained further if the records are under review or audit until the review or audit is complete. These records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of the **Contractor**, **TDMHDD**, TDCI, HCFA or TennCare. Prior approval for the disposition of records must be requested from **TDMHDD** if the provider contract is continuous;

3.9.2.13 **TDMHDD**, TDCI, TennCare, the United States Department of Health and Human Services, Office of Inspector General, and Comptroller shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this CONTRACT including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records;

3.9.2.14 Provide for monitoring, whether announced or unannounced, of services rendered to **Participants** and to **Judicials** sponsored by the **Contractor**;

3.9.2.15 Whether announced or unannounced, provide for participation and cooperation in any internal and external quality monitoring/quality improvement review (QM/QI), utilization review, peer review and appeal procedures established by the **Contractor** and/or **TDMHDD**;

3.9.2.16 Specify the **Contractor** shall monitor the quality of services delivered under the contract and initiate corrective action where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by **TDMHDD**;

3.9.2.17 Require the provider to comply with corrective action plans initiated by the **Contractor**;

3.9.2.18 Provide for submission of all reports and clinical information required by the **Contractor**;

3.9.2.19 Require safeguarding of information about **Participants** according to applicable state and federal laws and rules and as described in Section 6.14 of this CONTRACT;

3.9.2.20 Provide the name and address of the official payee to whom payment shall be made;

3.9.2.21 Make full disclosure of the method and amount of compensation or other consideration to be received from the **Contractor**;

3.9.2.22 Provide for prompt submission of information needed to make payment;

3.9.2.23 Provide for payment and appropriate denial of claims submitted by the provider in accordance with Section 3.13.2 of this CONTRACT between the **Contractor** and **TDMHDD**;

3.9.2.24 Specify the provider shall accept payment or appropriate denial made by the **Contractor** (or, if applicable, payment by the **Contractor** supplementary to the **Participant's** third party payor) as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the **Participant**, his or her parents or guardians, spouses, or other legally responsible persons;

3.9.2.25 Specify at all times during the term of the contract, the provider shall indemnify and hold **TDMHDD**, TennCare, and TDCI harmless from all claims, losses, or suits relating to activities undertaken pursuant to the CONTRACT between **TDMHDD** and the **Contractor**. This indemnification may be accomplished by incorporating Section 6.12 of this **TDMHDD**/**Contractor** CONTRACT in its entirety in the provider contract or by use of other language developed by the **Contractor** and approved by **TDMHDD**;

3.9.2.26 Require the provider to secure general liability, professional liability, and workers compensation insurance coverage as is necessary to adequately protect the plan's **Participants** and the **Contractor** under this CONTRACT. The provider shall provide such insurance coverage throughout the term of the provider contract and upon execution of the provider contract furnish the **Contractor** with written verification of the existence of such coverage. The amount of the insurance shall be in accordance with Section 3.3.4;

3.9.2.27 Specify both the **Contractor** and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the **Contractor** plan;

3.9.2.28 Provide the contract incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be

incorporated into the contract as they become effective. In the event changes in the contract as a result of revisions in applicable federal or state law materially affect the position of either party, the **Contractor** and provider agree to negotiate such further amendments as may be necessary to correct any inequities;

3.9.2.29 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the contract termination date, or early termination of the contract and such change shall only be valid when reduced to writing, duly signed and attached to the original of the contract, unless TennCare shall approve an alternative procedure;

3.9.2.30 Specify both parties recognize in the event of termination of this CONTRACT for any of the reasons described in Section 5.1. of this CONTRACT, the provider contract shall terminate immediately and the provider shall immediately make available to **TDMHDD**, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACT. The provision of such records shall be at no expense to **TDMHDD**;

3.9.2.31 Contain a provision requiring resolution of disputes by arbitration, approved by TDCI. This provision shall specify if any dispute arises between the parties involving a contention by one party that the other has failed to perform its obligations and responsibilities under the contract, then the party making such contention shall promptly give written notice to the other and **TDMHDD**. Such notice shall set forth in detail the basis for the party's contention, and shall be sent by Certified Mail - Return Receipt Requested. The other party shall within thirty (30) calendar days after receipt of the notice provide a written response seeking to satisfy the party that gave notice regarding the matter as to which notice was given. Following such response, or the failure of the second party to respond to the complaint of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then that party shall so notify the other party and the matter shall be promptly submitted to inexpensive and binding arbitration in accordance with the Tennessee Uniform Arbitration Act at Tennessee Code Annotated, §§29-5-301 et seq., with the costs of establishing any arbitration procedure being borne by the **Contractor**. **TDMHDD** shall have no involvement in said arbitration except (1) to enforce this subsection, (2) to approve the arbitration procedure proposed by the **Contractor**, and (3) to voluntarily intervene if **TDMHDD** deems intervention to be in the best interest of the system provided, however, **TDMHDD** shall not be bound by said arbitration. If at any time **TDMHDD** decides a particular dispute should be in a court or administrative tribunal of competent jurisdiction, **TDMHDD** shall notify the parties to the dispute of its decision to refer the dispute to a court or administrative tribunal of competent jurisdiction and said arbitration process shall cease and the dispute shall be heard in said court or administrative tribunal. The only exception to the arbitration process shall be resolution of the cost for emergency medical services in Section 3.4.6.1 and providers of services under Tennessee Code Annotated, §33-2-601. If a dispute between the parties involving a claim submitted by a provider to the **Contractor** is not resolved prior to entry of a final decision by the arbitrator(s), then the prevailing party at the arbitration shall be entitled to award of reasonable attorney's fees and expenses from the non-prevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the

dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or $500.00 whichever amount is greater.

The arbitration procedure proposed by the **Contractor** shall be submitted to the TennCare Division of TDCI for review and approval within thirty (30) calendar days of execution of this CONTRACT. If the **Contractor** has an existing alternative arbitration procedure, the **Contractor** may submit the existing arbitration procedure to the TennCare Division of TDCI for review and approval. The TennCare Division of TDCI shall approve or deny the proposed arbitration procedure within thirty (30) calendar days after the receipt of the proposal from the **Contractor**. Any subsequent modification to the arbitration procedure by the **Contractor** must also be reviewed and approved by the TennCare Division of TDCI. Said modification shall be sent by Certified Mail-Return Receipt Requested to the TennCare Division of TDCI which shall approve or deny the proposed modification within thirty (30) calendar days after the receipt of said modification from the **Contractor**;

3.9.2.32 Include a conflict of interest clause as stated in Section 6.5 of this CONTRACT;

3.9.2.33 State the provider shall not receive more than one hundred five percent (105%) of the rate negotiated between the **Contractor** and provider as the final payment amount, so any incentive or bonus paid the provider by the **Contractor** shall not exceed five percent (5%) of the rate negotiated between the **Contractor** and the provider. The provider contract shall specify the provider shall be liable for a portion of any excess benefit costs associated with the provision of services pursuant to the provider contract and shall describe the methodology to be used in the allocation of such excess benefit costs. The provider contract shall also specify the provider shall not be required to absorb any amount of the **Contractor**'s excess administrative and/or management fees;

3.9.2.34 Specify the provider shall be required to accept TennCare reimbursement amounts for services provided under the contract between the provider and **Contractor** to TennCare Partners Program **Participants** and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the **Contractor**;

3.9.2.35 Specify the provider must adhere to the Quality of Care Monitors included in this CONTRACT as Attachment C. The Quality of Care Monitors shall be included as part of the provider contract between the **Contractor** and the provider;

3.9.2.36 Specify the provider shall have at least one hundred and twenty (120) calendar days and no more than one hundred and eighty (180) calendar days from the date of rendering mental health or substance abuse services to file a claim with the **Contractor**. The **Contractor** in its discretion may allow a provider additional time to file such a claim, but under no circumstances can the **Contractor** shorten the one hundred and twenty (120) calendar day time provision;

3.9.2.37 Specify the provider contract shall include a signature page which contains the **Contractor** and provider typed names, provider company with titles, and dated signatures of all appropriate parties;

3.9.2.38 Specify attachments and/or exhibits to the provider contract contain language and definitions consistent with this CONTRACT;

3.9.2.39 Specify the provider contract must number contract pages in sequential order;

3.9.2.40 Specify the provider submit to the **Contractor** the necessary information so the **Contractor** can determine the average unit costs pursuant to Section 3.12.9.4;

3.9.2.41 Specify that the provider has acceptable and compatible informal and formal appeal processes;

3.9.2.42 Specify the provider must comply with claims processing requirements as referenced in Section 3.13.2.

3.9.2.43 Specify that the contract is not exclusive with respect to any service or geographic area.

3.9.2.44 No agreement executed between the **Contractor** and a provider shall require the provider to assume financial risk for the provision of services which are not directly or indirectly furnished by that provider to a **Participant** in the TennCare Partners Program. The term indirectly means the provider retains ultimate management and control over the services furnished to **Participants** in the TennCare Partners Program. The **Contractor** may request the TennCare Division of TDCI to provide, in advance, a written opinion whether a proposed contract provision is in compliance with this section, and the TennCare Division of TDCI must respond to any such request within thirty (30) calendar days after receipt of the request by the TennCare Division of TDCI. **TDMHDD**, in addition to any and all remedies set forth in this CONTRACT, may also commence an action against the **Contractor** in accordance with Section 6.11 of this CONTRACT to recover from the **Contractor** any losses incurred by a provider as a result of the **Contractor**'s breach of this section. Any amounts recovered by **TDMHDD** which are for losses incurred by a provider as a result of the **Contractor**'s breach of this section shall be returned without interest to the provider.

3.9.2.45 All provider agreements must include language which informs providers of the package of benefits EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs.

3.10 Participant Involvement

3.10.1 The **Contractor** must submit for **TDMHDD** approval its policies and procedures with respect to **Participant** involvement. These policies and procedures must include, at a minimum, the following elements:

3.10.1.1 The requirement that mental health case management service plans and other relevant treatment plans document **Participant** involvement, including **Participant**/family member signature on the plan and upon each subsequent plan review where appropriate and a description of how this requirement will be met;

3.10.1.2 The requirement that **Participant** education materials include statements regarding the **Participants**' right to involvement in treatment decisions, their ability to

choose and change service providers, and a description of how this requirement will be met;

3.10.1.3 The requirement that provider education include materials regarding the rights of **Participants** to be involved in treatment decisions and a description of how this requirement will be met;

3.10.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for **Participant** involvement in treatment planning; and

3.10.1.5 **Participant** satisfaction surveys prior to implementation

3.10.2 The **Contractor** shall provide an education plan for all **Participants** regarding mental health and substance abuse issues; education must occur on a regular basis. At a minimum, educational materials must include information on medications and their side effects; mental disorders and treatment options; self-help groups and other community support services available for **Participants**.

3.10.3 The **Contractor** shall establish a **Contractor** Advisory Committee which is accountable to the **Contractor**'s governing body to provide input and advice, according to the following requirements:

3.10.3.1 The Advisory Committee must be comprised of at least 51% consumer and family representatives, of which the majority must include families of adults with Serious and/or Persistent Mental Illness and families of children with Serious Emotional Disturbances;

3.10.3.2 There must be equal geographic representation;

3.10.3.3 There must be cultural and racial diversity;

3.10.3.4 There must be representation by providers and consumers (or family members of consumers) of substance abuse services;

3.10.3.5 At a minimum, the Advisory Committee must have input into policy development, planning for services, service evaluation, and **Participant**, family member and provider education;

3.10.3.6 Meetings must be held at least quarterly;

3.10.3.7 Reimbursement for travel is paid by the **Contractor**;

3.10.3.8 The **Contractor** must submit two semi-annual reports to **TDMHDD** regarding the activities of the Advisory Committee; and

3.10.3.9 The **Contractor**, as Advisory Committee membership changes, must submit current membership lists to **TDMHDD**.

3.11 Quality Monitoring/Quality Improvement Program

3.11.1 The **Contractor** must implement a Quality Monitoring Plan in accordance with **TDMHDD** requirements as referenced in Attachment C.

3.11.2 The **Contractor** shall submit for the approval of **TDMHDD** minimum protocols for the treatment and prevention of each of the major clinical mental disorders listed on Axis I and Axis II of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) of the American Psychiatric Association. **TDMHDD** reserves the right to require the **Contractor** to modify its minimum protocols in accordance with standards which are to be uniformly applied to all **Contractor**s under this or another CONTRACT.

3.11.3 The **Contractor** must maintain national accreditation by National Committee for Quality Assurance, Joint Commission Accreditation Hospital Organizations (JCAHO) or another nationally recognized accrediting body which is acceptable to **TDMHDD.** **3.11.4** The **Contractor** must adhere to the clinical **Best** Practice Guidelines as they are developed or finalized by **TDMHDD.**

3.12 Records and Reporting Requirements

3.12.1 General Requirements

3.12.1.1 The **Contractor** is responsible for generating all transactions/transaction files and complying with all the reporting requirements established by Tenncare. Each transaction must be date/time stamped. TennCare shall provide the **Contractor** with the appropriate reporting formats, record layouts**,** instructions, submission tables, and technical assistance when required. TennCare reserves the right, at its discretion, to require the **Contractor** to recreate, reconstruct or re-sort records/reports/transaction files using the same or different reporting formats, record layouts, instructions, and submission timetables as specified by TennCare. Requests to recreate, reconstruct or re-sort such reports/files will be considered Ad Hoc reports/files or continuous reports/files and shall be due within time periods specified by TennCare. The minimum data elements required for transaction files are described in Attachment D of this CONTRACT.

3.12.1.2 The **Contractor** must submit to TennCare all required transaction files utilizing the Electronic Data Interfaces (EDI) of the IBM International Network (IBMIN) unless otherwise stated by TennCare. The **Contractor** will be responsible for all costs involved with the IBMIN, including setup, software, account ID, and transmit cost both to and from the "mailbox" whether opened by the **Contractor** or by the State.

3.12.1.3 The **Contractor** must provide TennCare with quarterly files for comparisons between TennCare or TennCare databases and the **Contractor**'s database. The **Contractor** shall reconcile any discrepancies.

3.12.1.4 The **Contractor** shall be responsible for its Information Systems concerning all aspects for (1) System Backups, (2) Off-site security storage of same System Backups, (3) System Restores, (4) Disaster Recovery Plan and Procedures, and (5) all security needs and considerations. The **Contractor** is responsible for all documentation and procedures concerning all five (5) of these items, insuring they are kept up-to-date, accurate, and accessible.

3.12.1.5 TennCare has the right to obtain a free, legal, licensed copy(s) of the **Contractors**' software, physical data base structure(s), and ongoing upgrades as

available relating to admissions/intake, patient tracking, all components of billing, and any other aspect of the **Contractor's** system software considered useful to TennCare and the providers it supports. It will be TennCare's choice as to which **Contractor's** software best satisfies TennCare needs and operating system environment. TennCare has the right to choose all the software from one particular **Contractor** without receiving any protest whatsoever from any other BHO. It is not the intention of TennCare the other **Contractors** will be required to use this software. This software will be made available to HCFA upon request.

3.12.2 Provider Enrollment Reporting

The **Contractor** shall furnish to **TDMHDD** at the time of application a listing of all providers enrolled in the **Contractor**'s provider network including, but not limited to, agencies and individual physicians, mental health case managers, psychologists, licensed clinical social workers, registered nurses, nurse practitioners, certified alcohol and drug abuse counselors, other mental health or substance abuse professionals, pharmacies, hospitals, etc. This listing shall include regularly enrolled providers, specialty or referral providers, and any other provider which may be enrolled for purpose of payment for services provided out-of-plan. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to **TDMHDD** on a basis specified by **TDMHDD**. The minimum data elements required for this listing may be found in Attachment D.1 of this CONTRACT.

3.12.3 Participant Intake Reporting

The **Contractor** shall furnish to **TDMHDD** information regarding **Participants** who have presented for mental health or substance abuse services. This information includes but is not limited to identifying information, additional demographic information not collected at the time of enrollment in TennCare, and other individual information unique to users of mental health and/or substance abuse services. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to **TDMHDD** on a basis specified by **TDMHDD**. The minimum data elements required to be provided are identified in Attachment D. 2 of this CONTRACT.

3.12.4 Participant Assessment Reporting

The **Contractor** shall furnish to **TDMHDD** information regarding the CRG assessment or TPG assessment of **Participants** who have presented for mental health or substance abuse services or who have been referred for an assessment prior to obtaining such services. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to the **TDMHDD** on a basis specified by **TDMHDD**. The minimum data elements required to be provided are identified in Attachments D.3 and D.4 of this CONTRACT.

3.12.5 Participant Encounter Reporting

The **Contractor** shall furnish to TennCare information regarding individual encounters (individual units of service provided to **Participants**). Encounter information will be submitted for all covered services as listed in Section 2.6. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to TennCare on a basis specified by **TDMHDD** and the Bureau of TennCare. The minimum data elements required to be provided are identified in Attachment D.5 of this CONTRACT.

If a national standardized encounter reporting format is developed, the **Contractor** agrees to implement this format if directed to do so by **TDMHDD**.

3.12.6 Participant Outcome Reporting

The **Contractor** shall furnish to **TDMHDD** information regarding outcomes for **Participants** who have presented for mental health or substance abuse services including, but not limited to: changes in mental health status or psychiatric symptomatology, changes in psychosocial functioning, changes in quality of life indicators, and **Participant** satisfaction. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to the **TDMHDD** on a basis specified by **TDMHDD**. The minimum data elements required to be provided are identified in Attachment D.6 of this CONTRACT.

3.12.7 Enrollee Information, Weekly Reporting

The **Contractor** shall submit weekly reports in an electronic format, unless otherwise specified or approved by TennCare in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of information for a change in the enrollee's address and/or selection of MCO plan. This report shall include enrollees who move outside the **Contractor's** service area as well as enrollees who move to a new address within the Contractor's service area. The **Contractor** agrees to work with the state to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within 90 days of notification from TennCare, the **Contractor** shall also be required to include in this report, any information which is known by the **Contractor** that may affect a **Participant's** TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements required for this report can be found in Attachment D of this CONTRACT. This notice may be accomplished through a written form or as an electronic media update, as mutually agreed upon by the **Contractor** and TennCare.

3.12.8 Enrollee Verification Information on Request

TennCare may provide the **Contractor** with a report in electronic format containing enrollees for whom TennCare has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the **Contractor** shall immediately, or within time frames, if any, specified by TennCare, provide TennCare with any information that is known by the **Contractor** that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability, including limited coverage and exclusionary riders to policies, information regarding an enrollee which has been incarcerated, change of residence or residence outside the State of Tennessee. TennCare shall not specify timeframes less than thirty (30) calendar days from the **Contractor's** receipt of such report. The minimum data elements required for this report can be found in Attachment D of this CONTRACT.

3.12.9 Financial Reporting

3.12.9.1 The **Contractor** shall file with the TennCare Division of TDCI an annual report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated, §56-32-208. The **Contractor** in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report.

3.12.9.2 The **Contractor** shall file with the TennCare Division of TDCI a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These reports shall be filed on or before June 1 (covering first quarter of the current year), September 1 (covering second quarter of current year), December 1 (covering third quarter of current year), ***and March 1 (covering fourth quarter of previous year),*** of each calendar year. Each quarterly report shall also contain an income statement detailing the **Contractor**'s revenues earned and expenses incurred as a result of the **Contractor**'s participation in the State of Tennessee's TennCare Partners Program as well as an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with the National Association of Insurance Commissioners guidelines.

3.12.9.3 The **Contractor** shall, when determining liabilities on its annual report and quarterly financial reports, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, or unpaid or for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities shall be computed in accordance with procedures to be established by the TennCare Division of TDCI upon reasonable consideration of the ascertained experience and character of the **Contractor**.

3.12.9.4 The **Contractor** shall report to **TDMHDD** monthly summary reports of encounter data and annually the average cost and accumulative average cost of providing each definable unit of services for which encounter data will be reported in accordance with Section 3.12.5. The **Contractor** is not relieved from this obligation because the **Contractor** has any subcontracts for the provision of any such unit of service, regardless of the method of payment to the sub**Contractor**(s).

The average cost for each unit of services shall be calculated by dividing the total cost paid and/or incurred for each unit of service for the reporting period by the number of units of services for each unit of service provided to a **Participant** during the same reporting period. The **Contractor** is not required to include the amounts paid to and/or incurred by a sub**Contractor** in which the **Contractor** does not have a significant business interest. For the purposes of this Section, significant business interest shall be defined in accordance with 42 CFR, Subpart B, §455.101, adjusted for the accumulative months in the reporting period.

The **Contractor** shall maintain at its principal offices in Tennessee all data from sub**Contractor**s, on which the average cost was calculated.

3.12.10 Summary Reporting

The **Contractor** shall furnish to **TDMHDD** all requested summary reports. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted to **TDMHDD** on a basis specified by **TDMHDD**. These summary reports include, but are not limited to, the following:

3.12.10.1 Performance Measures Reporting;

3.12.10.2 Quality Management Reporting;

3.12.10.3 Critical Occurrences Reporting;

3.12.10.4 Service System Profile Reporting;

3.12.10.5 Service Utilization Reporting;

3.12.10.6 Service Specific Reporting;

3.12.10.7 CRG/TPG Assessment Reporting;

3.12.10.8 Mental Health Case Management Referral Reporting.

3.12.11 Medical Records Requirements

The **Contractor** must meet all applicable state and federal requirements and implement a Quality Monitoring Program Plan in accordance with **TDMHDD** requirements as referenced in Attachment C. The Quality Monitoring Program Plan must have prior written approval from **TDMHDD**.

3.12.12 Availability of Records

The **Contractor** shall make all records available at the **Contractor**'s expense for review, audit, or evaluation by authorized federal, state, and Comptroller of Treasury personnel. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records to be sent by mail will be sent to **TDMHDD** within fifteen (15) calendar days of request and at no expense to **TDMHDD**.

3.13 Accounting Requirements

3.13.1 General Requirements

The **Contractor** shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this CONTRACT and any other costs and expenditures made under the CONTRACT.

Specific accounting records and procedures are subject to **TDMHDD** and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the CONTRACT period and for five (5) years thereafter.

3.13.2 Claims Processing

The **Contractor** shall pay or appropriately deny within thirty (30) calendar days of receipt ninety five percent (95%) of all clean claims submitted by contract and non-contract providers. [The term "pay" means the **Contractor** shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the **Contractor**. The term "appropriately deny" means that the **Contractor** shall notify the provider that the claim has been denied and shall include in the notification the reason for denial (such reason will be consistent with the terms of this CONTRACT)]. Thereafter, the **Contractor** shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The **Contractor** shall also process within sixty (60) calendar days of receipt all claims submitted by contract and non-contract providers. The term "process" means the **Contractor** must pay the claim or advise the provider that a submitted claim is (1) a "denied claim" and specify all reasons for denial or (2) a claim that cannot be denied or allowed due to insufficient information and/or documentation and specify in detail all information and/or documentation needed from the provider in order to allow or deny the claim. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

To the extent a provider contract requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than the time period specified in the contract between the provider and the **Contractor** or sub**Contractor**, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a sub**Contractor**, or (iii) if the **Contractor** is required to compensate the provider directly, within five (5) calendar days after receipt of the capitation payment and supporting Remittance Advice information from TennCare.

The **Contractor** shall provide to TennCare in a format prescribed by TennCare, a weekly claims processing report that includes the following:

- number of unpaid claims in inventory by service type:;
- aging of unpaid claims by service type;
- average time from receipt to final payment of claim by service type;
- approximate value of unpaid claims by service type;
- number of phone calls received; and
- approximate waiting time for response to the call.

This weekly summary report shall be due in the TennCare office on or before 12:00 noon Wednesday of the following week.

Failure by the **Contractor** to comply with the claims processing and payment standards described in this Section may result in the assessment of liquidated damages as described in Section 5.3.3.3. Additionally, because the claims processing and payment requirements pursuant to this contract are more stringent than the claims processing and payment requirements of the Balanced Budget Act of 1997, the **Contractor** recognizes that failure by the **Contractor** to comply with the claims processing and payment requirements in this contract may be a violation of applicable federal laws.

3.13.3 Resolution of All Previous Claims Processing Issues

When applicable, the **Contractor** shall be required to appropriately process all backlogged claims in accordance with time frames specified TDMHDD. For purposes of this requirement, backlogged claims include, but are not limited to, all claims which have been received but not processed to final and correct disposition and the resolution of each and every payment dispute related to the provision of service.

At its discretion, the state will assess the current status of the **Contractor's** claims processing performance to determine if changes in claims processing procedures have been made and if performance has improved to acceptable levels.

Failure by **Contractor** to comply with any of the claims processing requirements stated in Section 3.13.4 of this contract will result in the state issuing a sixty (60) day notice of termination of the contract between the State and the **Contractor** in accordance with Section 5.1 of the contract. Termination of the contract shall not preclude the state from exercising any other remedies available under the contract.

3.13.4 Audit Guidelines

The state and the **Contractor** agree the state may develop comprehensive audit guidelines for the monitoring of **Contractor**'s claims processing performance and include these audit guidelines in a future amendment to this contract. These claims processing audit guidelines may consist of specified performance criteria and liquidated or other damages for **Contractor**'s failure to meet the specified performance criteria. The state and **Contractor** agree the **Contractor** shall have an opportunity to participate in the development of these claims processing audit guidelines.

3.14 Monitoring and Audit Requirements

3.14.1 Audit Requirements

The **Contractor** shall cause an audit to be performed by a licensed certified public accountant of its business transactions, including but not limited to, the financial transactions made under this CONTRACT. Such audit shall be performed in accordance with General Accepted Audited Standards. The **Contractor** shall submit to the TennCare Division of TDCI the audited financial statements (prepared under generally accepted accounting principles) covering the previous calendar year by May 1 of each calendar year. The audited financial statements shall include the following:

a. an income statement addressing the TennCare Partners Program operations of the **Contractor,**
b. a reconciliation of the audited financial statements to the National Association of Insurance Commissioners annual report filed with the TennCare Division of TDCI, and
c. a summary of transactions between the **Contractor** and the **Contractor's** related parties, including a non-affiliated management company, using the format prescribed by TDCI. For the purpose of identifying the **Contractor's** related parties, "affiliate" and "control" shall have the same definitions as those set forth in Tennessee Code Annoted, Section 56-11-201 and the definition of "affiliate" set forth in T.C.A. Section 56-32-202(11).

The contract for such audits shall be subject to prior approval of the State Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Account". If terms included in the standard contract to audit accounts differ from those in this CONTRACT, this CONTRACT

takes precedence. These financial reporting requirements shall supersede any other reporting requirements required of the **Contractor** by the TDIC, and the TDIC shall exact any necessary rule or regulation to conform with this provision of this CONTRACT.

The **Contractor** shall submit to the TennCare Division of TDCI the audited financial statements (using statutory accounting principles and prepared under generally accepted accounting principles) covering the previous calendar year by May 1 of each calendar year. The audited financial statements shall include an income statement addressing the TennCare Partners Program operations of the **Contractor.** The contract for such audits shall be subject to prior approval of the State Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". If terms included in the standard contract to audit accounts differ from those in this CONTRACT, this CONTRACT takes precedence.

3.14.2 Records Maintenance

The **Contractor** shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred under this CONTRACT as well as medical information relating to the individual **Participants** for the purpose of audit requirements. Records other than medical records may be kept in an original paper state, or preserved on micromedia or electronic format. Medical records shall be maintained in their original form. These records, books, documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the CONTRACT period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the CONTRACT period, these records shall be available at the **Contractor**'s chosen location subject to the approval of **TDMHDD**. If the records need to be sent to **TDMHDD**, the **Contractor** shall bear the expense of delivery. Prior approval of the disposition of **Contractor** and sub**Contractor** or provider records must be requested and approved by **TDMHDD** if the CONTRACT or subcontract is continuous.

3.14.3 Accessibility of Records for Monitoring

For purposes of monitoring under the CONTRACT, the **Contractor** shall make available to **TDMHDD** or its representatives and other state and federal personnel authorized by law or otherwise all records, books, documents, and other evidence pertaining to this CONTRACT, as well as appropriate administrative and/or management personnel who administer the plan. The monitoring shall occur periodically during the CONTRACT period and may include announced or unannounced visits, or both.

3.14.4 Independent Review

TDMHDD may select a private review organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the **Contractor**. The results of the review shall be provided to **TDMHDD** and to the **Contractor** and shall be available, on request, to the United States Department of Health and Human Services, the Office of Inspector General and General Accounting Office.

3.15 Fiscal Management

3.15.1 General Requirements

The Contractor shall be responsible for sound fiscal management of the plan developed under this CONTRACT. The **Contractor** must adhere to the minimum guidelines described below.

3.15.2 Capitation Payments

The **Contractor** agrees to accept the capitation payments remitted by TennCare in accordance with Section 4.7 of this CONTRACT. These capitation payments are payment in full for all services provided pursuant to this CONTRACT and for all administrative and management fees and profits of the Contractor in providing or arranging for covered services.

However, the **Contractor** shall only be allowed to retain ten percent (10%) of the monthly capitation amount paid by TennCare for administrative and management fees and profits, with the remaining 90% of the capitation payments being made available for providing or arranging direct mental health and substance abuse services to **Participants** and payment of any applicable premiums tax by the **Contractor** to the State. Any and all benefit costs in excess of the amounts allowed pursuant to this CONTRACT shall be the responsibility of the **Contractor.** TDMHDD shall not be liable for any excess benefit costs distributed as a reduction to contract providers. Any administrative and management fees and profits exceeding the 10% limitation shall be borne by the **Contractor .**

3.15.3 Contractor 's Management Fee

The **Contractor** shall each calendar year be allowed to retain ten percent (10%) of all amounts paid by TennCare to the **Contractor** under this CONTRACT for administrative expenses, including but not limited to any management fee paid to a third party by the **Contractor** but not including the payment of any applicable premiums tax by the **Contractor** to the state, and profits, if any (hereinafter referred to as the "**Contractor**'s management fee"). The remaining ninety percent (90%) of the amounts paid by the Bureau of TennCare to the **Contractor** under this CONTRACT must be expended to provide covered direct mental health and substance abuse services to **Participants** in the **Contractor**'s plan and to satisfy any applicable premiums tax owed by the **Contractor** to the state.

Any and all administrative expenses in excess of the **Contractor**'s management fee shall be the responsibility of the **Contractor**. **TDMHDD** shall not be liable for any excess administrative costs of the **Contractor** distributed as a reduction to contract providers.

No later than July 15 of each calendar year, the **Contractor** shall calculate the total amount of payments for covered services provided during the preceding calendar year and accrued as of December 31 of the preceding calendar year, as well as any premiums tax paid by the **Contractor** to the state. The **Contractor** shall provide a detailed explanation of this calculation to **TDMHDD** and the TennCare Division within TDCI. If the actual accrued amount paid by the **Contractor** for covered services and premiums tax is less than ninety percent (90%) of the amounts paid the **Contractor** by TennCare for the preceding year, then the **Contractor** shall remit to **TDMHDD** one hundred percent (100%) of the difference by no later than August 15 of that calendar year.

Under no circumstances shall any provider receive from the **Contractor** as an incentive or bonus more than five percent (5%) of the rate negotiated between the **Contractor** and provider as the final payment amount.

3.15.4 Incentive Payments

Solely to enhance the **Contractor**'s performance under this CONTRACT, the state shall establish a BHO Performance Evaluation Committee to determine whether incentives shall be paid to the BHO for meeting certain performance criteria to be established by the Committee. Such incentives shall in no event exceed forty percent (40%) of the **Contractor**'s management fee for the applicable calendar year. The determination of whether the **Contractor** has complied with the conditions for obtaining any incentive rests within the sole discretion of the Committee and is not subject to review.

3.15.5 Return of Funds

The **Contractor** must return to TennCare any overpayments due or funds disallowed under this CONTRACT. Such funds shall be considered TennCare funds and shall be refunded to TennCare. The refund shall be due within thirty (30) calendar days after notification to the **Contractor** by TennCare unless this deadline is extended by TennCare in writing.

3.15.6 Interest

Interest generated through investments made by the **Contractor** of funds paid to the **Contractor** under this CONTRACT shall be the property of the **Contractor** and shall be used at the **Contractor**'s discretion.

3.15.7 Third Party Resources

The TennCare Partners Program shall be the payer of last resort for all covered mental health and substance abuse services. The **Contractor** shall be entitled to, and shall exercise, full subrogation rights and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to **Participants** under this CONTRACT and recover any such liability from the third party.

3.15.7.1 If the **Contractor** has determined third party liability exists for part or all of the services provided directly by the **Contractor** to a **Participant**, the **Contractor** shall make reasonable efforts to recover from third party liable sources the value of services rendered.

3.15.7.2 If the **Contractor** has determined third party liability exists for part or all of the services provided to a **Participant** by a sub**Contractor** or provider, and the third party will make payment within a reasonable time, the **Contractor** may pay the sub**Contractor** or provider only the amount, if any, by which the sub**Contractor**'s or provider's allowable claim exceeds the amount of third party liability; or, the **Contractor** may assume full responsibility for third party collections for service provided through a subcontract or referral provider. The term "reasonable time" shall mean not less than thirty (30) nor more than sixty (60) calendar days.

3.15.7.3 The **Contractor** may not withhold payment for services provided to a **Participant** if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time.

3.15.7.4 All funds recovered from third parties will be treated as offsets to claims expense for the **Contractor**.

3.15.7.5 The **Contractor** is required to notify the provider of the identity of any third party resource when the availability of the resource was the basis for the **Contractor**'s denial of the provider's claim.

3.16 Notification of Legal Action Against the Contractor

The **Contractor** shall provide to the Commissioner of **TDMHDD** and to the Deputy Commissioner of the TennCare Division of TDCI immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the **Contractor** by a provider or **Participant** which is related to the **Contractor**'s responsibilities under this CONTRACT, including but not limited to notice of any arbitration proceedings instituted between a provider and the **Contractor**. Records of persons with serious emotional disturbance or mental illness must be maintained in conformity with Tennessee Code Annotated, §33-3-104(2). Records of persons whose confidentiality is protected by 42 CFR Part 2 must be maintained in conformity with that rule or Tennessee Code Annotated, §33-3-104, whichever is more stringent. The **Contractor** shall ensure all tasks related to the provider contract are performed in accordance with the terms of this CONTRACT.

3.17 Title VI Information

In order to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act requirements which prohibit discrimination based on race, color or national origin, the **Contractor** shall have available for inspection at all times and shall be required to furnish to **TDMHDD** the information in Sections 3.17.1 through Section 3.17.4 below. The **Contractor** shall appoint a staff person to be responsible for Title VI compliance on behalf of the **Contractor**. The **Contractor** does not have to require Title VI compliance be the sole function of the designated staff member. However, the **CONTRACTOR** shall identify the designated Title VI compliance staff member to **TDMHDD** by name. At such time this function is redirected, the name of the staff member who assumed the duties shall be identified to **TDMHDD.** The **Contractor** shall be required to inquire as to the race and/or national origin of providers and **Contractor** staff and shall report to **TDMHDD** the information, if any, furnished by the providers and **Contractor**'s staff in response to such an inquiry. The **Contractor** shall be prohibited from requiring providers or **Contractor** staff to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding employment, participation in the **Contractor**'s provider network or in determination of compensation amounts.

3.17.1. On an annual basis, a copy of the **Contractor**'s personnel policies and other operational policies that, at a minimum, emphasize non-discrimination in hiring, promotional, contracting processes and participation on advisory/planning boards or committees.

3.17.2. On a quarterly basis, a listing of all complaints/appeals filed by employees, enrollees or sub**Contractor**s in which discrimination is alleged in the **Contractor**'s TennCare Plan. Such listing shall include, at a minimum, the identity of the party making the complaint, the party's relationship to the BHO, the circumstances of the complaint and the resolution of the complaint.

3.17.3. On a quarterly basis, a summary listing totaling the number of supervisory personnel by race and sex. Such listing shall separate categories for total supervisory personnel, number of white male supervisors, number of white female supervisors, the number of black female supervisors, the number of black male supervisors, the number of other race female supervisors and the number of

other race male supervisors. For purposes of this listing, supervisory personnel shall include supervisors, managers, directors, etc.

3.17.4. On an annual basis, a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race, ethnic origin and shall be sorted by CSA. Each provider type (e.g., physician, dentist, etc.) shall be reported separately within the CSA and primary care providers shall be reported separately from other physician specialties.

SECTION 4. TDMHDD RESPONSIBILITIES

4.1 General Responsibilities

TDMHDD shall be responsible for the administration of this CONTRACT. Such administration shall be conducted in good faith with the best interests of all **Participants**, the state and the citizens it serves being the prime consideration.

TDMHDD may delegate or authorize other parties in writing to perform any of the services or functions specified in this CONTRACT as being the responsibility of **TDMHDD**. **TDMHDD** may, upon written notice to the **Contractor**, delegate or authorize the services or functions to be performed by another party.

4.2 Interpretations

Any dispute between the **Contractor** and **TDMHDD** concerning the clarification, interpretation and application of any provision of this CONTRACT or any federal and state laws and regulations governing or in any way affecting this CONTRACT shall be resolved by **TDMHDD**. When a clarification, interpretation and application is required, the **Contractor** will submit written requests to **TDMHDD**. **TDMHDD** will contact the appropriate agencies in responding to the request. Any clarifications received pursuant to requests for clarification or interpretation shall be forwarded upon receipt to the **Contractor**. Nothing in this Section shall be construed as a waiver by the **Contractor** of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, and/or policy.

4.3 Eligibility and Enrollment

TDMHDD and TennCare shall be responsible for verifying the eligibility of Participants and for assigning them to and disenrolling them from the Contractor's plan.

4.3.1 Basic Participants

The TennCare and **TDMHDD** shall be responsible for verifying the eligibility of all Basic Participants and for assigning them to and disenrolling them from the **Contractor's** Plan.

4.3.2 Priority Participants

TennCare shall be responsible for assigning to and disenrolling from the **Contractor**'s plan all **Priority Participants**.

4.3.2.1 **TDMHDD** shall be responsible for approving the eligibility of all **Priority Participants** who are enrollees in the TennCare Program.

4.3.2.2 **TDMHDD** shall be responsible for determining the eligibility of all **Priority Participants** who are not enrollees in the TennCare Program. All such persons must first have applied for TennCare benefits and been denied enrollment by TennCare on the basis of ineligibility for Medicaid and availability of health insurance. Such persons must have been determined to be **Priority Participants** pursuant to Section 2.2.2.2. **TDMHDD** shall be responsible for enrolling these persons in the TennCare Partners Program in accordance with Section 2.3.2 and for disenrolling them in accordance with Subsection 2.2.2.2.3.3 and Section 2.4.1. TennCare shall be responsible for assigning these persons to BHOs.

4.3.3 Judicials

TDMHDD shall be responsible for temporarily assigning all **Judicials** to the **Contractor**'s plan. In the event a **Judicial** is referred by a court of competent jurisdiction, the referral shall be construed as if the referral was a temporary assignment by **TDMHDD**. The **Contractor** shall be responsible only for the services as prescribed under the terms of this CONTRACT or as required by the statute or court order under which the **Judicial** was referred. The preceding sentence notwithstanding, the **Judicial** shall not be considered as a **Participant** in the **Contractor**'s plan.

Except for **Judicials**, TennCare shall arrange for the **Contractor** to have daily updated eligibility information in the form of on-line computer access. TennCare shall also arrange for the **Contractor** to receive a monthly list of all the **Participants** who become ineligible or disenrolled from the **Contractor**'s plan or who have been determined to have moved out of the State of Tennessee**.**

4.4 Approval Process

At any time approval from **TDMHDD** is required in this CONTRACT, such approval shall not be considered granted unless **TDMHDD** issues its approval in writing. Deliverable requirements are outlined in Attachment H. Material requiring **TDMHDD** approval includes, but is not limited to, the following:

4.4.1 The **Contractor**'s provider network and any additions and deletions;

4.4.2 In accordance with Section 3.6, any marketing plans and all related materials;

4.43 Any additional benefits and services generally made available or provided by the **Contractor** or through its provider network;

4.4.4 The **Contractor**'s pro forma contract(s) with providers and any amendments thereto;

4.4. 5 Any subcontracts which may be proposed for any services other than the services and benefits provided to **Participants**;

4.4.6 **Appeal** procedures;

4.4.7 Reporting procedures;

4.4.8 Indemnity language in provider agreements if different from the standard indemnity language found in Section 6.12 of this CONTRACT or the pro forma contracts which are reviewed in accordance with Section 4.4.4 above;

4.4.9 Quality Assurance/Quality Improvement procedures;

10 Arbitration procedures.

4.4.11 Transition Plan in accordance with Section 5.1.3.1.

4.5 Inspections and Monitoring

4.5.1 Facility Inspection

TDMHDD, TennCare, TDCI, HCFA, or any agents of these agencies may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the **Contractor** in fulfilling the obligations under this CONTRACT. Inspections may be made at any time during the term of this CONTRACT and without prior notice.

4.5.2 Monitoring

TDMHDD, TDCI and HCFA, or their agents, shall at least annually monitor the operation of the **Contractor** for compliance with the provisions of this CONTRACT and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of **Contractor**'s facilities, auditing and/or review of all records developed under this CONTRACT, including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, review of management systems and procedures developed under this CONTRACT and review of any other areas or materials relevant to or pertaining to this CONTRACT. The monitoring agency shall prepare a report of its findings and recommendations and require the **Contractor** to develop corrective action plans as appropriate.

4.6 Responses to Participants

4.6.1 Appeals

TennCare shall establish and maintain an informal review process and formal appeal procedures whereby, any **Participant** or anyone authorized to act on their behalf may grieve or appeal an adverse action by the **Contractor** in accordance with Section 3.5. The **Contractor** specifically acknowledges, in accordance with 1200-13-12-.11 of the TennCare Rules of TDFA , it is bound by the decision of **TennCare**, whether as the result of an informal review or formal appeal, and shall not appeal any decision rendered by Te**nnCare**.

4.6.2 Consumer Affairs

TDMHDD shall maintain an Office of Consumer Affairs in order to respond to member inquiries and complaints.

4.7 Payment Terms and Conditions

TennCare shall make monthly payments to the **Contractor** for its satisfactory performance and provision of covered services under this CONTRACT. Each payment shall be paid on or before the fifth (5th) business day of each month. Each payment shall be calculated as follows:

4.7.1 Calculation of Capitation Payments

4.7.1.1 Capitation Rates

The following Capitation Rates and payment amounts shall be applicable to this CONTRACT.

For the period beginning January 1, 2001, the total amount of funding available for monthly capitation payments will be (to be determined). Each month TennCare will calculate the number of TennCare enrolled **Priority Participants** in each BHO. Each BHO will receive the payment rate for each TennCare enrolled **Priority Participant** in its plan less any applicable adjustments for coinsurance. The remaining amount available from the (to be determined) will be divided by the remaining TennCare Partners Program **Participants**, including State only **Participants** described in Section 2.2.1.2 of this CONTRACT, who are not enrolled in TennCare. A variable capitation rate will be determined for each of these Participants and paid to the BHO according to the number of **Participants** in its plan.

4.7.1.2 Basic Calculation

Each monthly Capitation Rate, as specified or determined in Section 4.7.1.1, shall be multiplied by the number of **TennCare Enrolled Priority Participants** in the **Contractor**'s plan as of the first (1st) day of the month for which payments are to be made. Judicials shall not be counted until such time as they are enrolled in, or assigned to, the **Contractor**'s plan by the State under Section 2.3.2 of this CONTRACT. No capitation shall be made for Judicials.

4.7.1.2.1 The Capitation Rate specified in Section 4.7.1.1 shall be multiplied by the number of **TennCare Enrolled Priority Participants** in the **Contractor**'s plan. For the purposes of this Section, the persons to whom the specified rate is applicable must meet the requirements specified in Sections 2.2.1.1 and 2.2.2.2. Any payment made in accordance with this Section shall be subject to verification of each individual's status regarding compliance with these requirements.

4.7.1.2.2 The Capitation Rate calculated in accordance with Section 4.7.1.2 shall be multiplied by the total of number of **Basic Participants** and the number of state-only **Priority Participants** (see Section 2.2.1.2 of this CONTRACT) enrolled in the **Contractor**'s plan. For the purposes of this Section, the persons to whom the specific capitation rate is applicable must meet the requirements of Section 2.2.2.1 or the requirements of Sections 2.2.1.2 and 2.2.2.2.

4.7.1.3 Calculation of Adjustments for Preceding Month(s)

The results of Section 4.7.1.2 shall be adjusted by the number of **Participants** who were not enrolled in or assigned to the **Contractor**'s plan for all the days of the preceding month(s) for which payments have been made. A daily capitation rate shall be calculated for each of the capitation rates specified in or calculated in accordance with Sections 4.7.1.1 and 4.7.1.2 by dividing each appropriate rate which was in effect for the applicable

month by the number of days in the same month. Each resulting quotient shall be multiplied by the total number of actual days the appropriate category of **Participants** were enrolled in or assigned to the **Contractor**'s plan. Nothing in this Section shall be construed as requiring the State to make an adjustment every month for the immediately preceding month's payment or preventing the state from making positive or negative periodic reconciliations of any payments previously made to the **Contractor**.

4.7.1.4 Adjustment to the Basic Calculation

The result of Section 4.7.1.3 shall be compared to the basic calculation made for the preceding month in accordance with Section 4.7.1.2. If the preceding month's basic calculation is less than the amount calculated in Section 4.7.1.3, the amount calculated for the current month pursuant to Section 4.7.1.2 shall be increased by the difference between the preceding month's basic calculation and the result of Section 4.7.1.3; if the preceding month's basic calculation is greater than the amount calculated in Section 4.7.1.3, the amount calculated for the current month pursuant to Section 4.7.1.2 shall be reduced by the difference between the preceding month's basic calculation and the result of Section 4.7.1.3.

4.7.1.5 Increased Availability of Funding When TennCare Enrollment Exceeds 1,225,000

Two million dollars will be available annually for distribution to the BHOs if enrollment in the TennCare Program exceeds 1,225,000. One-twelfth of the $2 million, or $166,667 will be added to the total monthly captiation rate, as applicable, for each month in which TennCare enrollment exceeds 1,225,000. In the event enrollment in the TennCare program exceeds 1,500,000, the state shall review the capitation payment methodology and the funding available for distribution to the BHOs.

4.7.2 10% Withholds

The amount calculated pursuant to Section 4.7.1 shall be reduced by ten percent (10%) each month. The purpose of this ten percent (10%) withhold is to assure the **Contractor**'s compliance with all terms and conditions of this CONTRACT. Such terms and conditions shall include, but are not limited to:

4.7.2.1 The requirements of Section 2.6, as they relate to provision of covered services;

4.7.2.2 The requirements of Sections 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9 and 3.10;

4.7.2.3 The Quality Monitoring and Quality Improvement Program, as referenced in Section 3.11 and Attachment C;

4.7.2.4 The Records and Reporting Requirements, specified in Section 3.12;

4.7.2.5 The TennCare Waiver, any applicable amendments thereto, and any Special Terms and Conditions imposed upon the TennCare Waiver or any amendments; and

4.7.2.6 Any other term of this CONTRACT which **TDMHDD** may designate.

If, by the end of the month for which the ten percent (10%) was withheld, **TDMHDD** has not identified any deficiency(ies) in the **Contractor**'s compliance with the terms and

conditions of this CONTRACT for that month, TennCare shall pay, in addition to the amount calculated in accordance with Section 4.7.1 for the next month, the ten percent (10%) withhold for the preceding month.

If **TDMHDD** identifies any deficiency(ies) in the **Contractor**'s compliance with the terms and conditions of this CONTRACT and provides the **Contractor** written notice of the deficiency(ies), TennCare will retain the ten percent (10%) withhold for the preceding month. TennCare will continue to retain the ten percent (10%) withhold and will, in addition to the original withheld amount, withhold and retain ten percent (10%) from each subsequent month's Capitation Payment, calculated in accordance with Section 4.7.1, until such time as the **Contractor** has corrected all deficiencies for which written notification has been given to the **Contractor**.

The accumulated withheld amount(s) will not be paid to the **Contractor** until the **Contractor** has been determined by **TDMHDD** to have corrected the original deficiency(ies) and any subsequent deficiency(ies) in the **Contractor**'s compliance with the terms and conditions of this CONTRACT. Payment of the withheld amount(s) will be made with the Capitation Payment for the month immediately following the month the deficiency(ies) were corrected. No interest will be paid on any of the withheld amounts.

Any amounts withheld for one hundred eighty (180) consecutive days for the same compliance deficiency(ies) shall be permanently retained by TennCare on the one hundred eightieth (180th) consecutive day and shall not be paid to the **Contractor**. If the same deficiency(ies) continue beyond one hundred eighty (180) consecutive days, TennCare may declare the **Contractor** ineligible to receive any future payments of the ten percent (10%) withholds until such time as the **Contractor** corrects the deficiency(ies) for which the ten percent (10%) was withheld.

4.7.3 Other Adjustments

The failure of TennCare to make any of the following adjustments, which are in addition to the amount(s) withheld in accordance with Section 4.7.2, shall not prejudice **TDMHDD**'s right or in any way prevent TennCare from making the adjustment(s) at any future date.

4.7.3.1 Liquidated Damages

TennCare may reduce payments to the **Contractor** by the amount of any liquidated damages not received from the **Contractor** by TennCare on or before the date the liquidated damages are to be paid. TennCare, at its discretion, may withhold from any later payments due the **Contractor** any subsequent liquidated damages payable to TennCare. (See Section 5 of this CONTRACT.)

4.7.3.2 Actual Damages

TennCare may reduce payments to the **Contractor** by the amount of actual damages, including incidental and consequential damages, resulting from any breach of this CONTRACT by the **Contractor**. (See Section 5 of this CONTRACT.)

4.7.3.3 Cost of Partial Breach

TennCare may reduce payments to the **Contractor** by the amounts determined in

accordance with Section 5.2.3.7 of this CONTRACT.

4.7.3.4 Amounts Due State

TennCare may withhold from any payment due the **Contractor** any other amounts due the state by the **Contractor**, including but not limited to any amount due **TDMHDD or TennCare** as the result of any state or federal audit or examination of the **Contractor**.

Any adjustments made pursuant to section 4.7.3 and amounts owed to **TDMHDD or TennCare** as damages or as cost to cure a breach or provide any defaulted services shall not be counted in determining the percentage of the capitation payments paid for the provision of covered services and payment of premiums tax in accordance with Section 3.15.2.

SECTION 5. REMEDIES

5.1 Termination

In the event of the termination of this CONTRACT, either at the expiration and non-renewal of this CONTRACT or as an early termination prior to the expiration of this CONTRACT, neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred under this CONTRACT prior to the effective date of such early termination. The **Contractor** shall also not be relieved of its responsibilities for payment or appropriate denial of payment for all services provided to **Participants** in accordance with this CONTRACT and the provider contracts. **TDMHDD or TennCare** shall have no responsibilities for any liabilities incurred by the **Contractor** which arise as a result of its performance under this CONTRACT.

5.1.1 Termination Procedure

Written notice may be given in the case of the expiration and non-renewal of this CONTRACT and shall be given in the case of the early termination of this CONTRACT. The notice shall be to the person designated in accordance with Section 1.2. In the event the notice does not comply with the terms of this agreement, the notice shall still be effective in all respects; however, **Contractor** may request clarification of the notice, and such request shall not affect the effectiveness or date of the notice.

5.1.1.1 Notice of Expiration

In the event of the expiration and the non-renewal of this CONTRACT, **TDMHDD** may cause to be delivered to the **Contractor** a written Notice of Expiration. The Notice of Expiration may specify or otherwise include at least the date of the Notice of Expiration and any requirements, consistent with Section 5.1.3, which are or are not to be imposed. The Notice of Expiration may be utilized if in the judgment of **TDMHDD** Sections 5.1.3.1.1 through 5.1.3.1.3 should be exercised or Section 5.1.3.2 is deemed applicable.

5.1.1.2 Notice of Termination

In the event of an early termination of this CONTRACT, the party initiating the

termination shall cause to be delivered to the other party a written Notice of Termination. The Notice of Termination shall specify or otherwise include the date of the Notice of Termination, the effective date of the early termination, the section of this CONTRACT under which early termination is requested, and any conditions of the termination, not inconsistent with the terms of this CONTRACT. In the event of termination for any reason, **TDMHDD** shall have the option of requiring the performance of the requirements of Section 5.1.2 (or their written waiver) or imposing any conditions of early termination not inconsistent with this CONTRACT.

5.1.2 Requirements of Termination

Unless otherwise specified below, the clauses in this Section shall apply to all terminations of this CONTRACT. After receipt of the Notice of Termination, if required, and except as directed by **TDMHDD** in writing or as otherwise required in Section 5, the **Contractor** shall:

5.1.2.1 Stop work under this CONTRACT in whole, or in part, immediately or in stages, as specified in the Notice of Termination;

5.1.2.2 In the case of an early termination, if appropriate, immediately terminate all marketing procedures and all contracts or terms thereunder relating to such permitted marketing activities;

5.1.2.3 Enter into no further subcontracts or provider contracts, except as necessary for the **Contractor** to fulfill its obligations under this CONTRACT as of the effective date of the early termination;

5.1.2.4 At the request of **TDMHDD**, assign to **TDMHDD** or its designee, in the manner and to the extent required by **TDMHDD**, all rights, title and interest of the **Contractor** under the terminated subcontracts and provider contracts, in which case **TDMHDD** or its designee shall have the right, at its discretion, to settle or pay any of the claims arising out of the continuation of and the termination of such subcontracts and provider contracts;

5.1.2.5 If not otherwise required under Section 5.1.3, complete performance under this CONTRACT, or in the case of an early termination, to the extent required under the Notice of Termination;

5.1.2.6 Prior to the submission of a final invoice, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts and provider contracts;

5.1.2.7 Take such action as may be necessary, or as **TDMHDD** may direct, for the protection of property related to this CONTRACT which is in possession of the **Contractor** and in which **TDMHDD** has or may acquire an interest;

5.1.2.8 Promptly make available to **TDMHDD**, or to such other party as **TDMHDD** shall designate, any and all records, whether medical or financial, related to the provision of services to or on behalf of the **Participants**; such records shall be in a form which, at the sole discretion of **TDMHDD**, is usable by the party to whom the records are sent; such records shall be provided at no expense to **TDMHDD**;

5.1.2.9 Promptly provide all information necessary to **TDMHDD** or another Contractor acting on behalf of **TDMHDD** for reimbursement of any outstanding claims at the time of

termination; such records shall be provided at no expense to **TDMHDD**.

5.1.3 Continuity of Services

The **Contractor** expressly acknowledges the services provided under this CONTRACT must be continued without interruption and, upon expiration or the early termination of this CONTRACT, a successor, either an agency of the State of Tennessee or another **Contractor**, may continue such services. The **Contractor** agrees to cooperate with any successor to effect an orderly and efficient transition to a successor.

5.1.3.1 Unless written notice to the contrary is received from **TDMHDD**, the **Contractor** agrees to the following:

5.1.3.1.1 The **Contractor** shall negotiate in good faith a Transition Plan with a successor to determine the nature and extent of the services to be provided by the successor and the **Contractor**. The Transition Plan shall be subject to the approval of **TDMHDD**. If **TDMHDD** does not approve the Transition Plan or if the parties cannot agree to the terms and conditions of the Transition Plan within fifteen (15) calendar days following the date of the Notice of Termination or the Notice of Expiration, or any other time period specified in writing by **TDMHDD**, **TDMHDD** shall determine the terms and conditions of the Transition Plan. The **Contractor** and the successor, as affirmed under this CONTRACT, expressly agree to abide by the terms and conditions of the Transition Plan as determined by **TDMHDD**.

5.1.3.1.2 The **Contractor** shall retain and make available sufficient qualified and experienced personnel during the transition period to ensure that the terms and conditions of this CONTRACT and of the Transition Plan are met.

5.1.3.1.3 The **Contractor** shall provide and continue to perform such services which are not inconsistent with the terms of this CONTRACT and which can reasonably be expected to be provided or performed in order to effect an orderly and efficient transition to a successor.

5.1.3.2 The Contractor agrees to the following only if written notice is received from TDMHDD:

The **Contractor** shall continue to serve or arrange for the provision of services to the **Participants** for a transition period of forty-five (45) calendar days from the later of the effective date of the termination or of the Transition Plan or until all the **Participants** can be transferred to another **Contractor's** plan.

During this transition period,TennCare shall continue to make payments to the **Contractor** in accordance with Section 4.7 of this CONTRACT.

5.1.4 Final Invoice

The **Contractor** shall submit the final invoice for payment to TennCare no more than one hundred fifty (150) calendar days after the effective date of any termination. If the **Contractor** fails to do

so, all rights to payment are waived. TennCare will not honor any requests submitted after the one hundred fifty (150) day period.

5.1.5 Final Payment

The final payment due the **Contractor** under the terms of this CONTRACT shall be paid within thirty (30) calendar days after the final approvable invoice is submitted within the one hundred fifty (150) day period specified in the preceding Section 5.1.4, subject to the following limitations:

5.1.5.1 The final payment may be withheld until **TDMHDD** receives from the **Contractor** all reports and information required pursuant to this CONTRACT and all written and properly executed documents as reasonably required by **TDMHDD** as the result of the termination.

5.1.5.2 The amount of the final payment may be reduced by the following:

5.1.5.2.2 Any other adjustment payable to TennCare in accordance with Section 4.7.3;

5.1.5.2.3 Any amounts owed to any Sub**Contractor**s or service providers and not paid or appropriately denied by the **Contractor** as of the date of the final payment;

5.1.5.2.4 Any amounts paid to Sub**Contractor**s or service providers in accordance with Section 5.1.2.4 to settle or pay any of the claims arising out of the termination of such subcontracts and provider contracts;

5.1.5.2.5 Any payment by **TDMHDD** or TennCare determined to have been erroneously paid;

5.1.5.2.6 Any financial liability payable to **TDMHDD** or TennCare as the result of audits completed after the effective date of the termination of this CONTRACT;

5.1.5.2.7 Except for termination due to the expiration and non-renewal of this CONTRACT and early termination in accordance with Sections 5.1.6.3 through 5.1.6.5, any damages sustained by **TDMHDD** as the result of the early termination;

5.1.5.2.8 In the case of any default, any cost incurred by **TDMHDD**, including legal fees and court cost incurred by the Office of the Attorney General, to enforce any provision of this CONTRACT or to collect any amount owed **TDMHDD**; and

5.1.5.2.9 Any interest charged on the amount reduced from the payment(s) due the **Contractor**; the interest shall be computed on such amount(s) at the same rate that the Tennessee Department of Revenue receives on the payment of delinquent taxes as set forth at Tennessee Code Annotated § 67-1-801(a).

5.1.5.3 **TDMHDD** or TennCare shall give the **Contractor** prior written notification, stating the reasons for and the amount and the anticipated date of any such deduction from the final

payment made under Section 5.1.5.2, and shall give the **Contractor** the right to object to the basis or amount of the deduction.

5.1.5.4 If the **Contractor** and **TDMHDD** or TennCare fail to agree on the amount of the final payment, **TDMHDD** or TennCare shall determine on the basis of the information available, the amount, if any, due the **Contractor**.

5.1.6 Reasons Supporting Termination

The CONTRACT may be terminated for any of the following reasons:

5.1.6.1 Termination by Expiration and Non-Renewal

In the event this CONTRACT expires and is not renewed with the **Contractor**, this CONTRACT shall terminate in accordance with Section 5.1.1.1.

5.1.6.2 Termination by Mutual Consent

TDMHDD and the **Contractor** may terminate this CONTRACT at any time by written mutual consent. Both parties shall sign the Notice of Termination. **TDMHDD** shall inform all affected **Participants** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan.

5.1.6.3 Termination by TDMHDD for Convenience

TDMHDD may terminate this CONTRACT immediately or in stages at any time by written notice given to the **Contractor** at least sixty (60) days before the effective date of such early termination. TennCare shall inform all affected **Participants** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan. Termination for convenience of **TDMHDD** shall include, but not be limited to, a material change in ownership of the **Contractor** or the **Contractor**'s failure to maintain the experience criteria listed in Section 3.1 of the BHO application. For purposes of this section, "material change in ownership" means a change in ownership prohibited under Tennessee code Annotated §56-32-222 for an HMO licensed in Tennessee.

5.1.6.4. Termination by TDMHDD for the Unavailability of Funds

This CONTRACT is subject to appropriation and availability of state and/or federal funds. In the event funds are not appropriated or are otherwise unavailable, **TDMHDD** reserves the right to immediately terminate this CONTRACT upon written notice given to the **Contractor**. TennCare shall inform all affected **Participants** of their disenrollment from the plan provided by the **Contractor** and the reasons for their not being reassigned to another plan. The termination shall not be a breach of this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination.

5.1.6.5 Termination by TDMHDD due to the Expiration, Suspension or Termination of the TennCare Waiver

This CONTRACT is subject to the continuation of the TennCare Waiver, Section 1115(a) Demonstration Project. In the event the TennCare Waiver expires or is suspended or

terminated for whatever reason, **TDMHDD** reserves the right to immediately terminate this CONTRACT upon written notice to the **Contractor**. The termination shall not be a breach of this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination. **TennCare** shall inform all affected **Participants** of their disenrollment from the plan provided by the **Contractor** and the reasons for their not being reassigned to another plan.

5.1.6.6 Termination due to the Contractor's Insolvency

5.1.6.6.1 The **Contractor** must, during the term of this CONTRACT, demonstrate sufficient financial capital to perform its obligations under this CONTRACT. If **TDMHDD** reasonably determines the **Contractor**'s financial condition is not sufficient to allow the **Contractor** to provide the services as described, **TDMHDD** may terminate this CONTRACT in whole or in part, immediately or in stages.

5.1.6.6.2 For the purposes of this Section, the **Contractor** shall be presumed to be insolvent and in a condition hazardous financially to **Participants**, creditors and the public, under any of the following circumstances:

5.1.6.6.2.1 The **Contractor** cannot demonstrate to the satisfaction of **TDMHDD** the **Contractor** has established and maintained the financial requirements set forth in Section 3.3.2 of this CONTRACT; or

5.1.6.6.2.2 A trustee, receiver or liquidator for all or a substantial part of the Contractor's property is appointed, or proceedings for bankruptcy, reorganization, arrangement or liquidation is instituted by or against the Contractor.

5.1.6.6.2.3 In the event the **Contractor** meets any of the above circumstances of insolvency or enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the **Contractor** shall notify **TDMHDD** by the quickest means possible, with written notification of the insolvency or bankruptcy being given within five (5) calendar days of the **Contractor**'s meeting the circumstances of insolvency or the initiation of the proceedings relating to the bankruptcy filing. In the case of insolvency, the notification shall include the circumstance of insolvency and the date the **Contractor** met the circumstance of insolvency. In the case of bankruptcy, the notification shall include the date on which the bankruptcy petition was filed and the identity of the court in which the bankruptcy petition was filed.

The **Contractor**'s insolvency or the filing of a petition in bankruptcy by or against the **Contractor** shall constitute grounds for termination for cause in accordance with Section 5.1.6.7, except the Notice of Breach and any cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

This provision is not intended to imply the state concedes the **Contractor** may file a bankruptcy petition under federal

bankruptcy laws.

5.1.6.7 Termination by TDMHDD for Other Causes

TDMHDD may also terminate this CONTRACT if it is determined the **Contractor** has breached the CONTRACT, as described in Section 5.2.

5.1.6.8 Termination by Contractor

This CONTRACT shall be valid for the period specified in Section 6.18 of the CONTRACT. The **Contractor** shall have the right six (6) months prior to the expiration of this CONTRACT to provide **TDMHDD** written notice of intent to terminate this CONTRACT one hundred and eighty (180) calendar days from the date of written notice received by **TDMHDD**. Such written notice may be either hand-delivered to **TDMHDD** with a signed statement from **TDMHDD** staff acknowledging receipt or may be mailed by Certified Mail, Return Receipt Requested. The written notice shall specify the last date of operation, such date being at least one hundred and eight (180) days from the documented receipt of the notice of termination. The **Contractor** shall comply with all terms and conditions in this CONTRACT during the close-out period.

5.2 Breach By Contractor

5.2.1 The **Contractor** shall be deemed to have breached this CONTRACT if any of the following occurs:

5.2.1.1 The **Contractor** submitted incorrect, misleading or falsified information as part of or in addition to its BHO Application or in response to questions concerning the **Contractor**'s BHO Application or any such additional information. **TDMHDD** shall, at its own discretion, determine whether or not the incorrect, misleading or falsified information would have altered the selection of the **Contractor** as a **Contractor** under this CONTRACT;

5.2.1.2 The **Contractor** no longer meets the applicable conditions or qualifications which were submitted as part of the BHO Application;

5.2.1.3 The **Contractor** fails to perform in accordance with any term or provision of this CONTRACT or any applicable law or regulation;

5.2.1.4 The **Contractor** renders only partial performance of any term or provision of this CONTRACT;

5.2.1.5 The **Contractor** engages in any act prohibited or restricted by this CONTRACT or by State or federal statute, rule or regulation; or

5.2.1.6 The **Contractor** fails to qualify for, or has had revoked, a license required to operate in the State of Tennessee or is suspended, debarred or otherwise becomes ineligible or excluded from participation in any covered service in accordance with Title 45, Code of Federal Regulations, Part 76, or any statute or rule of the State of Tennessee or in any other state, which in the opinion of **TDMHDD,** would result in the **Contractor** having its license suspended or revoked or failing to become licensed or being suspended, debarred or ineligible or excluded from entering into this CONTRACT if the cause for such action had occurred in Tennessee.

5.2.2 Notice of Breach

In the event of breach by the **Contractor**, **TDMHDD** shall provide the **Contractor** written Notice of breach. The Notice of Breach shall specify the date of the notice, each specific breach or term of this CONTRACT with which the **Contractor** has not complied, and any corrective action which must be taken by **Contractor** to cure each breach or non-compliance. The **Contractor** shall be allowed twenty (20) calendar days from the date of the Notice of Breach to cure each breach or non-compliance, unless the breach is one of those specified in Section 5.3.3; in this case **TDMHDD** shall provide **Contractor** a Notice of Breach but no cure period shall be applicable unless expressly provided in Section 5.3.3. Notwithstanding any provision herein to the contrary, in the event the Notice of Breach does not comply with the terms of this CONTRACT, the notice shall still be effective in all respects; however, the **Contractor** may request a clarification of such notice. Any such defect, request or clarification shall not affect the effectiveness or date of the Notice.

If the **Contractor** disagrees with the determination of breach or noncompliance or designated corrective action described in the notice, the **Contractor** shall nevertheless implement the corrective action, without prejudice to any rights the **Contractor** may have to later dispute the finding of noncompliance or designated corrective action.

The requirement for a Notice of Breach and any cure periods shall be available to the **Contractor** only in the event of breach under Section 5.2.1. In the event of repeated breaches of the same general nature, no Notice of Breach and opportunity to cure is required.

5.2.3 Remedies for Breach

In the event the **Contractor** fails to cure the breach within the time period provided, **TDMHDD** shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this CONTRACT or available by law. Failure to comply with these remedies may result in the immediate termination of this CONTRACT by **TDMHDD**, and the Notice of Breach and the cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

5.2.3.1 **TDMHDD** may initiate recovery of actual damages, including incidental and consequential damages, and any other remedy available by law or equity.

5.2.3.2 **TDMHDD** may require the **Contractor** to prepare a plan to correct cited deficiencies and to immediately, or within the time frames specified by **TDMHDD**, implement such plan.

5.2.3.3 **TDMHDD** may recover any and all liquidated damages provided for in this CONTRACT.

5.2.3.4 **TDMHDD** may require the **Contractor** to obtain a performance bond in the amount of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.3, as determined by **TDMHDD**, and any liquidated damages assessed against the **Contractor** and not paid as of the effective date of the performance bond.

5.2.3.5 **TDMHDD** may require the **Contractor** to obtain a payment bond in the amount of ninety percent (90%) of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.3, as determined by **TDMHDD**, and any

liquidated damages assessed against the **Contractor** and not paid as the effective date of the payment bond.

5.2.3.6 Each bond which may be required under Sections 5.2.3.4 or 5.2.3.5 must be issued by one or more corporate sureties, licensed in Tennessee by the TDCI, be on a form prescribed by **TDMHDD**, have attached a certified and current power of attorney appointing an attorney-in-fact who is licensed in and a resident of the State of Tennessee, and name **TDMHDD** as obligee or owner.

5.2.3.7 **TDMHDD** may declare a partial default; in the event **TDMHDD** declares a partial default, **TDMHDD** may, at its discretion, cure the breach and provide the defaulted service(s) itself or authorize another party to cure the breach and provide the defaulted service(s) and permanently withhold from any amounts due the **Contractor** the greater of the following:

5.2.3.7.1 Any amounts paid the **Contractor** to provide the defaulted service(s) by TennCare; and any damage incurred by the State; or

5.2.3.7.2 The cost to **TDMHDD** to cure the breach or to provide the defaulted service(s) by **TDMHDD** or by another party designated by **TDMHDD**, and any damage incurred by the state.

5.2.4 Failure to Enforce

The failure of **TDMHDD** to insist, in one or more instances, upon the performance of any term of this CONTRACT is not a waiver of **TDMHDD**'s right to future performance of such term, and the **Contractor**'s obligation for future performance of such term shall continue in effect.

5.3 Liquidated Damages

The parties agree due to the complicated nature of the **Contractor**'s obligations under this CONTRACT, it would be difficult or impossible to specifically ascertain or prove the amount of the damages suffered by **TDMHDD** as the result of any breach or non-compliance by the **Contractor** of its obligations under this CONTRACT.

5.3.1 Specific Acknowledgments

The **Contractor** represents and covenants the **Contractor** has carefully reviewed each specified liquidated damage described in this CONTRACT and agrees each liquidated damage is reasonable and represents probable actual damages which **TDMHDD** would sustain in the event of a breach or non-compliance.

5.3.1.1 Exclusion

The **Contractor** agrees the liquidated damages do not include any injury or damages sustained by a third party and the liquidated damages are in addition to any other amounts the **Contractor** may owe **TDMHDD**, including, but not limited to, amounts owed as overpayments, including excess administrative and management fees and profits in accordance with Section 3.15.3, amounts owed as actual damages, amounts owed to cure a partial default in accordance with Section 5.2.3.7, and amounts owed as indemnification in accordance with Section 6.12.

5.3.1.2 Date of Accrual

The **Contractor** agrees liquidated damages shall accrue on the date following the date the report or deliverable was due or the breach occurred subject to the cure period in Section 5.3.3, if any. With respect to reports and other deliverables, the submission of an incorrect report or a deficient deliverable shall be the same as if the report or deliverable had not been provided.

5.3.1.3 Failure to Enforce

The **Contractor** agrees **TDMHDD** is not obligated to assess liquidated damages before availing itself of any other remedy. **TDMHDD** may, at any time after liquidated damages have been assessed, choose to terminate one of more of the assessments of liquidated damages and avail itself of any other remedy available under this CONTRACT or by law or equity. The failure of **TDMHDD** to assess a liquidated damage or **TDMHDD**'s termination of one or more assessments of liquidated damages shall not prejudice **TDMHDD**'s right to or in any way prevent **TDMHDD** from assessing or re-assessing liquidated damages at any future date.

5.3.2 Payment

Liquidated damages shall begin to accrue in accordance with Section 5.3.1.2 and be payable on the first day of each month.

5.3.2.1 Interest

If the liquidated damages are not received by the due date, interest shall accrue in accordance with Subsection 5.1.5.2.9 and shall be effective on the date determined in accordance with Subsection 5.3.1.2.

5.3.2.2 Withholding Liquidated Damages

TennCare may, with the consent of **TDMHDD**, withhold any due and payable liquidated damages, including interest, from any amounts owed the **Contractor** and/or pursue collection of such amounts from the **Contractor**. These liquidated damages plus interest shall belong to the State.

5.3.2.3 Applicability to Capitation Payments

Assessed liquidated damages, whether paid or due, and any interest charged thereon shall be counted against the percentage for administrative and management cost and profits, and not against the percentage of the capitation payments paid for the provision of covered services and premiums taxes in accordance with Section 3.15.3

5.3.3 Schedule of Liquidated Damages

Liquidated damages shall accrue in accordance with the following schedule. In the event a cure period is authorized in accordance with Section 5.2.2 or elsewhere in this Section, and the reason for which the liquidated damage was assessed is not cured, or otherwise remains uncorrected or

deficient at the end of the cure period, the amount of the liquidated damages shall be two (2) times the amount specified in the following schedule, beginning on the date following the last day of the cure period; for each subsequent cure period, the amount of liquidated damages will be multiplied by the number of cure periods.

5.3.3.1 Records and Reports

5.3.3.1.1	**Participant Records**	**Frequency or Referenced Sections**	**Amount Per Record**	**Cure**
	5.3.3.1.1.1	Daily	$100 per Day	None
	5.3.3.1.1.2	Weekly	$200 per Day	None
	5.3.3.1.1.3	Semi-Monthly	$300 per Day	5 Days
	5.3.3.1.1.4	Monthly	$500 per Day	5 Days
	5.3.3.1.1.5	Bi-Monthly	$500 per Day	10 Days
	5.3.3.1.1.6	Semi-Annual	$500 per Day	20 Days
	5.3.3.1.1.7	Annual	$500 per Day	20 Days

5.3.3.1.2	**Summary Reports**	**Frequency or Referenced Sections**	**Per Report**	
	5.3.3.1.2.1	*ad hoc*	$100 per Day	None
	5.3.3.1.2.2	Daily	$200 per Day	None
	5.3.3.1.2.3	Weekly	$400 per Day	None
	5.3.3.1.2.4	Semi-Monthly	$600 per Day	None
	5.3.3.1.2.5	Monthly	$600 per Day	5 Days
	5.3.3.1.2.6	Bi-Monthly	$600 per Day	10 Days
	5.3.3.1.2.7	Quarterly	$600 per Day	15 Days
	5.3.3.1.2.8	Semi-Annual	$600 per Day	20 Days
	5.3.3.1.2.9	Annual	$600 per Day	20 Days

5.3.3.1.3	**Financial Reports**	**Referenced Section(s) or Attachment**	**Per Report**	
	5.3.3.1.3.1	3.12.7.1	$600 per Day	5 Days
	5.3.3.1.3.2	3.12.7.2	$600 per Day	5 Days
	5.3.3.1.3.3	3.12.7.3	$600 per Day	5 Days
	5.3.3.1.3.4	3.14.1	$600 per Day	5 Days

5.3.3.2 Deliverables

		Referenced Section(s)	**Amount**	**Cure**
5.3.3.2.1	Crisis Services	2.6.6	$500 per Day	5 Days
5.3.3.2.2	Financial Disclosure in Providers	3.3.1.2 3.3.5	Amount Paid to the Provider	5 Days
5.3.3.2.3	Maintaining a Complaint and Appeal System	3.3.1.4 3.5	$500 per Day	5 Days
5.3.3.2.4	Maintain Fidelity Bond	3.3.3.1	$500 per Day	10 Days
5.3.3.2.5	Proof of	3.3.3.2	$500 per Day	10 Days

	Coverage			
5.3.3.2.6	Maintain the Required Amount of Insurance	3.3.4	$500 per Day	10 Days
5.3.3.2.7	Ownership and Financial Disclosure	3.3.5	$500 per Day	5 Days
5.3.3.2.8	Identification Card	3.4.1	$10 per Day per Participant	15 Days after Assignment
5.3.3.2.9	Explanation of Benefits	3.4.2	$50 per Day per Participant	15 Days after Assignment
5.3.3.2.10	Marketing	3.6	$500 per Day	5 Days
5.3.3.2.11	Staffing	3.7	Monthly Salary and Benefits Paid to Last Employee for Each Month Each Position is Vacant After 3 Months	None
5.3.3.2.12	Telephone Access	3.7.3	See Performance Measures	
5.3.3.2.13	Provider Site License	3.8.1	Amount Paid during the Period Each Site was Unlicensed	None
5.3.3.2.14	Provider Staff License	3.8.2	Amount Paid during the Period Each Site was Unlicensed	None
5.3.3.2.15	Credentialing Manual	3.8.4	$500 per Day	5 Days
5.3.3.2.16	Provider Relations Plan	3.8..5	$500 per Day	20 Days
5.3.3.2.1.7	Performance Measure Standards	Attachment E	See Attachment E	
Failure to process and pay claims in a timely manner		3.13.2	$1,000 per calendar day beginning on the first day the requirement is not met	None
Failure to provide a covered service to an enrollee under age 18 which results in the enrollee entering state custody		3.4.3.3.3	$ 500 per calendar day for each day the individual remains in state custody	None
Failure to provide a written		3.5	$500 per	None

notice or provision of a defective notice of denial, reduction, termination, suspension, or delay of covered services.		occurrence per case	
Failure to provide a written discharge plan or the provision of a defective discharge plan.	3.4.3.2.3	$1,000 per occurrence per case	None
Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TennCare to do so or within a longer period of time which has been approved by TennCare upon a plan's demonstration of good cause.	2.6 3.5 3.2.30 3.13.2	$500 per day beginning on the next calendar day after default by the plan.	
Imposing arbitrary utilization guidelines or other quantitative coverage limits.	2.6 Table 1	$500 per occurrence	
Services wrongfully withheld where enrollee was not receiving the service and the enrollee went without coverage of the disputed service while an appeal on the service was pending.	3.5	An amount sufficient to at least offset any savings the Contractor achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense.	
Failure to complete corrective action plans as required by TennCare.	3.5.2 3.9.2 4.5.2	$500 per calendar day for each day the corrective action is not completed as required.	
Failure to comply with the notice requirements of the TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	3.5	$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is	

		not handled according to the provisions set forth by this Agreement or required by TennCare.	
Failure to provide continuation of services where enrollee was receiving the service as required by TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	3.5	$500 per occurrence	

5.4 Other Remedies

The parties shall also have any other remedies set forth in other Sections of this CONTRACT.

SECTION 6. MISCELLANEOUS TERMS AND CONDITIONS

6.1 Applicable Laws, Rules and Policies

The **Contractor** agrees to comply with all applicable federal and State laws, rules, and executive orders which include, but are not limited to:

6.1.1 Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, excepting those parts waived under the TennCare Waiver, Section 1115(a) Demonstration Project , the Amendment to the TennCare Waiver, known as the "The TennCare Partners Program", and any Special Terms and Conditions imposed on the TennCare Waiver and the Amendment thereto;

6.1.2 The Amendment to the TennCare Waiver, known as "The TennCare Partners Program" and any Special Terms and Conditions imposed thereon;

6.1.3 The TennCare Waiver, Section 1115(a) Demonstration Project, having the reference number 11-C-99638/4-03, and the Special Terms and Conditions imposed thereon, which are not in conflict with the documents specified in Sections 5.1.1 and 5.1.2;

6.1.4 Title 45, Code of Federal Regulations, Part 74, General Grants Administration Requirements;

6.1.5 Titles 4, 33, 37, 47, 56 and 71 including the TennCare Drug Formulary Accountability Act of 1997, Tennessee Code Annotated;

6.1.6 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 *et seq*.);

6.1.7 Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 80;

6.1.8 Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment;

6.1.9 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 84;

6.1.10 The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 *et seq.*, which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Parts 90 and 91;

6.1.11 The Omnibus Budget Reconciliation Act of 1981, P.L.. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

6.1.12 Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, Title 28, Code of Federal Regulations, Parts 35 and 36.;

6.1.13 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program;

6.1.14 Confidentiality of Alcohol and Drug Abuse Patient Records, Title 42, Code of Federal Regulations, Part 2;

6.1.15 Federal Executive Order 11246, "Equal Employment Opportunity", as amended by federal Executive Order 11375, and as supplemented by Title 41, Code of Federal Regulations, Part 60, "Office of Federal Contract Compliance Programs. Equal Employment Opportunity, Department of Labor;

6.1.16 Tennessee Consumer Protection Act, Section 47-18-101 et seq, Tennessee Code Annotated;

6.1.17 Rules of the Tennessee Department of Health, (and as superseded by the TennCare rules of the Tennessee Department of Finance and Administration); Chapter 1200-13-12;

6.1.18 Rules of the Department of Mental Health and Developmental Disabilities, Rule 0940, *et seq.*; and

6.1.19 Gubernatorial Executive Orders;

6.1.20 All references in this CONTRACT or any Attachment thereto to the Tennessee Department of Mental Health and Developmental Disabilities **(TDMHDD)** shall be deemed to also be references to the Tennessee Department of Finance and Administration.

6.2 Use of Data

TDMHDD shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the **Contractor** resulting from this CONTRACT. **TDMHDD** shall not disclose proprietary information to the extent such information is conferred confidential status by state or federal law, except as permitted under these laws.

6.3 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this CONTRACT may be waived except by written amendment to this CONTRACT signed by all signatories to this CONTRACT or in the event the signatory is no longer empowered to sign this CONTRACT, the signatory's replacement, and forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings has occurred, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

6.4 Severability

If any provision of this CONTRACT is determined by a court of competent jurisdiction or agreed by the parties hereto to be overly broad in duration or substantive scope, such provision shall be deemed narrowed to the broadest term or extent permitted by applicable law. If any provision of this CONTRACT or the applicability thereof to any person or circumstance is determined by a court of competent jurisdiction or agreed by the parties hereto to be unlawful, void or, for any reason, unenforceable, such determination shall

not affect other provisions or applications of this CONTRACT which can be given effect without the invalid provision(s) or application; and, to that end, the provisions of this CONTRACT are held to be severable. In addition, if the laws or rules governing this CONTRACT should be amended or judicially interpreted as to render the fulfillment of this CONTRACT impossible or economically unfeasible, both **TDMHDD** and the **Contractor** will be discharged from further obligations created under the terms of this CONTRACT.

6.5 Conflict of Interest

The **Contractor** warrants no part of the total CONTRACT amount provided herein shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, sub**Contractor**, or consultant to the **Contractor** in connection with any work contemplated or performed relative to this CONTRACT unless otherwise authorized by the Commissioner, TDFA.

This CONTRACT may be terminated by TDMHDD if it is determined the **Contractor**, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The **Contractor** certifies no member of or delegate of Congress, the General Accounting Office, DHHS, HCFA or any other federal agency has or will benefit financially or materially from this CONTRACT.

The **Contractor** shall include the substance of this clause in all subcontracts and provider agreements.

6.6 Accessibility

TDMHDD or its authorized representative shall, at all reasonable times and upon reasonable notice, have access to the **Contractor**'s premises, or such other places where services are performed under this CONTRACT, and to all financial, medical and other records to ensure compliance with the terms and conditions of this CONTRACT and to investigate any complaints or appeals reported or made to **TDMHDD**. The **Contractor** shall include a clause to this effect in all subcontracts and provider agreements.

6.7 Attorney's Fees

In the event either party deems it necessary to take legal action to enforce any provision of this CONTRACT, and **TDMHDD** prevails, the **Contractor** agrees to pay all costs and expenses of such action, including attorney's fees of the State.

6.8 Assignment

This CONTRACT and the moneys which may become due hereunder are not assignable by the **Contractor** except with the prior written approval of **TDMHDD**.

6.9 Independent Contractor

It is expressly agreed the **Contractor** and any sub**Contractor**s or providers, and agents, officers, and employees of the **Contractor** or any sub**Contractor**s or providers, in the performance of this CONTRACT shall act in an independent capacity and not as agents, officers and employees of **TDMHDD** or the State of Tennessee. It is further expressly agreed this CONTRACT shall not be construed as a partnership or joint venture between the **Contractor** or any sub**Contractor** or provider and **TDMHDD** and the State of Tennessee.

6.10 Force Majeure

TDMHDD shall not be liable for any excess cost to the **Contractor** for **TDMHDD**'s failure to perform the duties required by this CONTRACT if such failure arises out of causes beyond the control of **TDMHDD** or is not the result of fault or negligence on the part of **TDMHDD**.

6.11 Disputes and Venue

The **Contractor** specifically acknowledges the sole and exclusive remedy for any claim by the **Contractor** against **TDMHDD** arising out of the breach of this CONTRACT shall be handled in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall give notice to **TDMHDD** of the substance and basis of its claim thirty (30) calendar days prior to filing the claim in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall comply with all terms and conditions contained within this CONTRACT pending the final resolution of the contested action. The venue for any cause of action concerning any provisions of this CONTRACT or the applicability thereof shall be in Davidson County, State of Tennessee.

6.12 Indemnification

The **Contractor** shall indemnify and hold harmless the State, its agencies and departments, as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of **Contractor** performance under this CONTRACT or **Contractor**'s failure to comply with the terms of this CONTRACT. The state shall give the **Contractor** written notice of each such claim or suit and full right and opportunity to conduct **Contractor**'s own defense thereof, together with full information and all reasonable cooperation; but the state does not hereby accord to the **Contractor**, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by Section 8-6-106, Tennessee Code Annotated.

The **Contractor** shall indemnify and hold harmless indemnified parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the **Contractor**'s or indemnified parties' performance under this CONTRACT. In any such action brought against the indemnified parties, the **Contractor** shall satisfy and indemnify the indemnified parties for the amount of any final judgment for infringement. The state shall give the **Contractor** written notice of each such claim or suit and full right and opportunity to conduct the **Contractor**'s own defense thereof, together with full information and all reasonable cooperation; but the state does not hereby accord to the **Contractor**, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by Section 8-6-106, Tennessee Code Annotated.

While the state will not provide a contractual indemnification to the **Contractor**, such shall not act as a waiver or limitation of any liability for which the state may otherwise be legally responsible to the **Contractor**. The **Contractor** retains all of its rights to seek legal remedies against the state for losses the **Contractor** may incur in connection with the furnishing of services under this CONTRACT or the failure of the state to meet its obligations under this CONTRACT.

6.13 Non-Discrimination

No person on the grounds of handicap and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2 of this CONTRACT, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this CONTRACT or in the

employment practices of the **Contractor**. The **Contractor** shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

6.14 Confidentiality of Information

The **Contractor** shall assure all materials and information directly or indirectly identifying any current or former **Participant** or potential **Participant**, which is provided to or obtained by or through the **Contractor**'s performance under this CONTRACT, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, and Title 42, Part 2, Code of Federal Regulations, and shall not be disclosed except in accordance with those Titles or to **TDMHDD** and HCFA of the United States Department of Health and Human Services, or their designees, as necessary to administrated this CONTRACT. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify any current or former **Participant** or potential **Participant**.

6.15 TDMHDD Financial Responsibility

Notwithstanding any provision in this CONTRACT to the contrary, **TDMHDD** and TennCare shall be solely responsible to the **Contractor** for the amount described herein and in no event shall **TDMHDD** or TennCare be responsible, either directly or indirectly, to any sub**Contractor**, provider or any other party who may provide the services described herein or otherwise.

6.16 Limitation on Payments to Providers and subContractors Related to the Contractor

The **Contractor** shall not pay more for services rendered by any provider or sub**Contractor** related to the **Contractor** than the **Contractor** pays to unrelated providers and sub**Contractor**s for similar services. A provider or sub**Contractor** is considered "related" to the **Contractor** if the provider or sub**Contractor** has an "ownership or control interest" or an "indirect ownership interest" in the **Contractor**, or the **Contractor** has an "ownership or control interest" or an "indirect ownership interest" in the provider or sub**Contractor**. The terms "indirect ownership interest," "ownership interest" and "ownership or control interest" shall have the same meaning as set forth in 42 CFR, Sections 455.101 and 455.102. Any payments made by the **Contractor** that exceed the limitations set forth in this section shall be considered non-allowable "payments for covered services" in calculating any monetary amount required to be returned by the **Contractor** to **TDMHDD** under Section 3.15.5 of this CONTRACT. No later than July 15 of each calendar year, the **Contractor** shall submit (with the information required in Section 3.15.3 of this CONTRACT): (1) a list of all related providers and sub**Contractor**s with which the **Contractor** has contracted during the preceding calendar year, and (2) a detailed explanation verifying that the payments made to such related providers and sub**Contractor**s are not in excess of the amounts allowed by this section. The provisions of this section shall be effective retroactive to January 1, 1997.

6.17 Prohibition of Contractor from Passing Withholds or Retentions to Providers or subContractors

The **Contractor** shall be prohibited from making any sub**Contractor** or provider responsible for paying all or any portion of a withhold retained by **TDMHDD** under Section 4.7.2 of this CONTRACT or any offset by **TDMHDD** against funds paid by the **Contractor**, unless the provider or sub**Contractor** is at fault in causing the retention of the withhold or the offset.

6.18 Term of the CONTRACT, and Duties of Contractor upon Expiration or Termination of the CONTRACT.

6.18.1 The **Contractor**, upon expiration or termination of the CONTRACT, shall perform the obligations set forth in Section 5.1 as well as the following obligations (hereinafter referred to as "continuing obligations"), for a period to extend to twenty-four (24) months after the effective date of termination.

6.18.1.1 The **Contractor** shall complete the processing of all claims incurred during the term of the CONTRACT in the manner described in Sections 3.13.2 and 3.13.3.

6.18.1.2 The **Contractor** shall file all reports concerning the **Contractor**'s operations during the term of the CONTRACT in the manner described in Section 3.12.

6.18.1.3 The **Contractor** shall process all appeals that occurred during the term of the CONTRACT in the manner set forth in Section 3.5.

6.18.1.4 The **Contractor** shall take whatever other actions are necessary in order to ensure the efficient and orderly transition of **Participants** from coverage under this CONTRACT to coverage under any new arrangement developed by **TDMHDD** in the manner set forth in Section 5.1.3.

6.18.2 During the time period following expiration or termination of the CONTRACT during which the **Contractor** is completing its continuing obligations, the **Contractor** shall maintain the fidelity bonds and insurance as set forth in Section 3.3.3 and 3.3.4. The **Contractor** shall also obtain a written and binding guarantee from a financially viable entity (which can be an owner of the **Contractor**) of all debts incurred by the **Contractor** up to a maximum amount of seven million dollars ($7,000,000) or the **Contractor**'s minimum net worth as defined at Section 3.3.2.1, whichever is greater. This guarantee must be approved by the TennCare Division of the TDCI; must be submitted by the **Contractor** to the TennCare Division within thirty (30) days after sending any written notice of termination or non-renewal; and must be approved or disapproved by the TennCare Division within fifteen (15) days after receipt. Approval of this guarantee by the TennCare Division relieves the **Contractor** from compliance with all financial requirements defined at Section 3.3.2. Failure to timely submit this guarantee, or to obtain approval of this guarantee by the TennCare Division, shall result in the automatic retention by TennCare of the ten percent (10%) withhold defined in Section 4.7.2, which shall be returned upon approval of the guarantee. Execution of any such guarantee does not relieve the **Contractor** from any and all legal debts and obligations incurred by the **Contractor**. The above described requirements of the **Contractor** shall cease upon **TDMHDD** approval of the final report described in Section 6.18.3.

6.18.3 Upon the expiration or termination of this CONTRACT, the **Contractor** shall submit reports to **TDMHDD** every thirty (30) calendar days detailing the **Contractor**'s progress in completing its continuing obligations under this CONTRACT. The **Contractor**, upon completion of these continuing obligations, shall submit a final report to **TDMHDD** describing how the **Contractor** has completed its continuing obligations. **TDMHDD** shall within twenty (20) calendar days of receipt of this report advise in writing whether **TDMHDD** agrees the **Contractor** has fulfilled its continuing obligations. If **TDMHDD** finds the final report does not provide evidence the **Contractor** has fulfilled its continuing obligations, then **TDMHDD** shall require the **Contractor** to submit a revised final report. **TDMHDD** shall in writing notify the **Contractor** once the

Contractor has submitted a revised final report evidencing to the satisfaction of **TDMHDD** that the **Contractor** has fulfilled its continuing obligations.

6.18.4 For purposes of calculation and payment of capitation rates, the effective dates contained in Section 4.7.1.1 and Section 4.7.1.2 shall apply. To be effective this CONTRACT must be approved by United States Department of Health and Human Services. This CONTRACT shall be in effect from January 1, 2001 through June 30, 2001.

At the option of the state, this CONTRACT shall be automatically renewed for up to an additional six (6) months in three (3) month intervals, not to extend beyond December 31, 2001, under the same terms and conditions, unless the **Contractor** shall notify the State of the intent to terminate this CONTRACT pursuant to the terms of Section 5.1.6.8 of this CONTRACT.

6.18.5 At the option of the state, the **Contractor** agrees to continue services under this CONTRACT when **TDMHDD** determines in **TDMHDD**'s sole discretion there is a public exigency that requires the contracted services to continue. Continuation of services pursuant to this section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed six (6) months. Thirty (30) days notice shall be given by TDMHDD before the option is exercised. The **Contractor** reimbursement during exigency periods shall be the established capitation rate in effect during the last three (3) months of this CONTRACT plus an inflation factor consistent with previous increases.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

CONTRACTOR:

_____ _____

Charles D. Klusener DATE
Chief Manager
PREMIER BEHAVIORAL SYSTEMS OF TENNESSEE, L.L.C.

TENNESSEE DEPARTMENT OF MENTAL
HEALTH AND DEVELOPMENTAL DISABILITIES

_____ _____

Elisabeth Rukeyser DATE
Commissioner

APPROVED:

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

_____ _____

C. Warren Neel, Ph.D. DATE
Commissioner

COMPTROLLER OF TREASURY:

_____ _____

John G. Morgan DATE
Comptroller of Treasury

ATTACHMENT A

DEFINITIONS

DEFINITIONS

The terms used in this CONTRACT shall be given the meaning used in the Rules and Regulations of TennCare applicable to the TennCare Partners Program. However, the following terms when used in this CONTRACT, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections 1 through 6 of this CONTRACT shall govern.

1. **Abuse (as adapted from definition in 42 CFR 455) -** Provider practices inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the TennCare program, or in reimbursement for services not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the TennCare program.

2. **Adverse Action** – As affecting TennCare benefits include, but are not limited to, delays, denials, reductions, suspensions or terminations of TennCare benefits, as well as to any other acts or omissions of TennCare or the Contractor which impair the quality, timeliness or availability of such benefits.

3.. **Alcohol Abuse** – A condition characterized by the continuous or episodic use of alcohol resulting in social impairment, vocational impairment, psychological dependence or pathological patterns of use.

4. **Alcohol Dependence** – Alcohol abuse which results in the development of tolerance or manifestations of alcohol abstinence syndrome upon cessation of use.

5. **Appeal Procedure -** The process for resolving an enrollee's right to contest any adverse action affecting medical assistance which was taken by the Contractor. The appeal procedure shall be governed by TennCare Rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.

6. **Basic Benefit Package** – An array of covered mental health and substance abuse services available to all enrollees in the TennCare Partners Program.

7. **Basic Participants** Persons enrolled in the TennCare Partners Program who have not been identified as Priority Participants. Children who are in the physical custody of the Department of Children's Services are considered to be Basic Participants in the TennCare Partners Program.

8. **Behavioral Health Care** – Generally recognized and accepted mental health and substance abuse services.

9. **Best Practice Guidelines** – A set of patient care strategies developed to assist providers in clinical decision making.

10. **Behavioral Health Organization (BHO) -** An entity which organizes and assures the delivery of mental health and substance abuse services.

11. Best Practice Guidelines - Guidelines for provision of health and behavioral health services to children in state custody.

12. Best Practice Network(BPN) - A network of providers that have agreed to render services in accordance with Best Practice Guidelines.

13. Best Practice Provider (BPP) - A provider (primary care, behavioral health, and dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in state custody, in accordance with the Remedial Plan and statewide Best Practice Guidelines, and who has agreed to be in the BHO network.

14. Capitation - A method of payment in which the organization delivering care provides a defined set of services to persons in a defined group for a single rate, usually calculated and paid on a per person per month basis.

15. Children At Risk of State Custody - Children who are determined to belong in one of the following two groups:

1. Children at imminent risk of entering custody - Children who are at risk of entering state custody as identified pursuant to T.C.A. 37-5-103 (10).
2. Children at serious risk of entering custody: Children whom DCS has identified as a result of a Children's Protective Services (CPS) referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody as a result of being unable to access behavioral health services.

16. Children with Special Health Care Needs Steering Panel (CSHCN Steering Panel) - An entity designed by the state to advise concerning the development of a health service system for children in state custody, in accordance with the Remedial Plan and the EPSDT Consent Decree.

17. Children's Center of Excellence (COE) - Tertiary care academic medical center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in state custody.

18. Clean Claim - A claim received by the BHO for adjudication which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid or appropriately denied by the BHO.

19. Clinical Inquiry - Contact regarding the status of, or information regarding, the direct care or treatment needs of an individual.

20. Clinically Indicated - A symptom or particular circumstance that indicates the advisability or necessity of a specific medical treatment or procedure after applying objective or standardized methods of evaluation.

21. Community Services Agency - A quasi-governmental entity which provides coordination of funds or programs designed for the care of children and other citizens in the State of Tennessee.

22. Community Services Area – (CSA) One or more counties in a defined geographical area in which a BHO is authorized to enroll and serve TennCare members in exchange for a monthly capitation fee. There are 12 CSAs in Tennessee, eight are in rural areas and four are located in metropolitan areas.

The following geographical areas shall constitute the twelve (12) Community Services Areas in Tennessee:

Northwest CSA	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton Counties
Southwest CSA	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy Counties
Shelby CSA	Shelby County
Mid-Cumberland CSA	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford Counties
Davidson CSA	Davidson County
South Central CSA	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties
Upper Cumberland CSA	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren Counties
Southeast CSA	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion Counties
Hamilton CSA	Hamilton County Counties
East Tennessee CSA	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane Counties
Knox CSA	Knox County
First Tennessee CSA	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson Counties

23. Consumer - An individual who uses a mental health or substance abuse service.

24. CFR (Code of Federal Regulations) – Regulations of the Health Care Finance Administration of the U.S. Department of Health and Human Services.

25. CRG (Clinically Related Group) - There are 4 clinically related groups which are mental health diagnostic categories and three of these categories include persons who have Severe and/or Persistent Mental Illnesses. A person with SPMI is an individual who has been classified as CRG 1, 2, or 3.

26. DCS Custody Children - Children who have been identified by DCS as belonging in one of the following groups:

1. Children in the legal and physical custody of DCS - Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.
2. Children in the legal, but not physical, custody of DCS - Children who are in DCS's legal custody but who reside with parents or guardians or other caretakers.

27. Developmental Disability means a condition based on having either a chronic disability or mental retardation.

28. Department of Children's Services (DCS) - The state agency having the statutory authority to provide a system of services for children in the custody of the state, or at risk of state custody.

29. Disenrollment - The discontinuance of a **Participant's** entitlement to receive covered services under the terms of this CONTRACT, and deletion from the approved list of **Participants** furnished by TDMHDD to the Contractor.

30. Emergency Medical Condition (as related to mental health and substance abuse treatment services) A mental health or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or to result in placing another individual at immediate substantial likelihood of serious harm.

31. Enchanced Benefits Package (EBP) The array of benefits available under the TennCare Partners Program to persons who have been identified with SPMI/SED.

32. Enrollee - Any eligible person who has enrolled in the **Contractor's** plan in accordance with the provisions of this CONTRACT.

33. Enrollment - The process by which an eligible person becomes a member of the **Contractor's** prepaid medical assistance plan.

34. EPSDT (Early, Periodic Screening, Diagnosis and Treatment) - Screening in accordance with professional standards, interperiodic screening and diagnostic services to determine the existence of physical or mental illness or conditions in recipients under age 21; and health care, treatment, and other measures to correct or ameliorate and defects and physical and mental illnesses and conditions discovered.

35. Executive Oversight Committee - The Committee designed by the state to have primary oversight responsibility for the implementation of a health service system for children in state custody, in accordance with the Remedial Plan and the EPSDT Consent Decree.

36. Federal Poverty Level.

37. Facility - Any premises (a) owned, leased, used or operated directly or indirectly by or for the **Contractor** or its affiliates for purposes related to this CONTRACT; or (b) maintained by a Sub**Contractor** or provider to provide services on behalf of the **Contractor.**

38. Fee For-Service - A method of making payment for health services based on fees set for

39. Fiscal Agent - Any agency who processes claims for payment and performs certain other related functions.

40. Full Time Equivalent Position

41. Forensics - As generally defined by TDMHDD - Court ordered evaluation (competency to stand trial and mental condition at the time of the crime) and treatment for pre-trial defendants and evaluation and treatment for individuals found not guilty by reason of insanity. For purposes of this CONTRACT, "Forensics" is defined as court ordered outpatient services for individuals found not guilty by reason of insanity or incompetent to stand trial.

42. Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

43. Health Care Financing Administration (HCFA) The federal agency responsible for oversight of the Medicaid and Medicare programs.

44. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32.

45. Implementation Team - A team of medical professionals under the direction of the Commissioner of Health who is charged with staffing the Executive Oversight Committee and overseeing the operational details of the Remedial Plan. The Implementation Team can determine if services which have been ordered for children at risk of custody and denied by the BHO are to be implemented while awaiting the results of an appeal.

46. IRS - Drugs that are Identical, Related or Similar to LTE drugs.

47. Judicial - An individual who requires **Judicial Services** as specified in Section 2.6.4 of This CONTRACT, but does not meet eligibility requirements for enrollment in the TennCare Partners Program. A Judicial is not an enrollee of TennCare or a **Participant** in the BHO plan and is entitled to BHO coverage of only those mental health evaluation and treatment services required by the statute or court order under which the individual was referred.

48. Judicial Services - Evaluation and treatment services required by statute as specified in Section 2.6.4 of this CONTRACT. Judicial services are provided by BHOs under the TennCare Partners Program to persons who require them by statute (specified in Section 2.6.5 of this CONTRACT), whether they are TennCare Partners Program enrollees or enter the TennCare Partners Program as Judicials.

49. Letter of Referral - A document developed by a BHO and a mental health or substance abuse provider which is not in the BHO's network, but which has responsibility for service to persons in the TennCare Partners Program.

50. LTE - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

51. Mandatory Outpatient Treatment (MOT) - Process whereby a person who was committed involuntarily and who requires outpatient treatment can be required to participate in that outpatient treatment in order to prevent deterioration in their mental condition.

52. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to enroll or accept any application for enrollment in the Contractor's prepaid health plan operated pursuant to this CONTRACT.

53. MCO - Managed Care Organization (includes HMOs and PPOs).

54. Medical Assistance or Medical Care Services - Covered services provided to enrollees of TennCare, including physical health, mental health and substance abuse services as permitted by HCFA Medicaid Demonstration Project # 11-W-00002/4 TennCare Program).

55. Medically Necessary -

a. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury;
b. Appropriate with regard to standards of good medical practice; and
c. Not solely for the convenience of an enrollee, physician, institution or other provider; and
d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means services for the enrollee's medical symptoms or condition require the services cannot be safely provided to the enrollee as an outpatient; and

e. When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

56. Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.

57. Mental Health and Substance Abuse Treatment Services (or Emergency Services) Covered inpatient and outpatient mental health and substance abuse treatment services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard and emergency ambulance transport.

58. Mental Health Facility - Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

59. Mental Health Services - Means the diagnosis, evaluation, treatment, residential personal care, habilitation, rehabilitation, counseling or supervision of persons who have a mental illness.

60. Mental Illness – Means a psychiatric disorder, alcohol dependence, or drug dependence, but does not include mental retardation or other developmental disabilities.

61. Non-Clinical Inquiry - Contact regarding the status of, or information regarding, non-treatment areas such as eligibility, provider information, BHO information.

62. Non-Contract Provider - Any person, organization, agency or entity not directly or indirectly employed by or through the **Contractor** or any of its subContractors pursuant to the agreement between the **Contractor** and TDMHDD.

63. Out-of-Plan Services - Services provided by a non-CONTRACT provider.

64. Participant - An individual who is enrolled in the TennCare Partners Program by virtue of enrollment in TennCare or enrollment in a BHO only due to TDMHDD determination under Section 2.2.1.2 of this CONTRACT.

65. Post-stabilization Care Services - Non-emergency mental health or substance abuse treatment services subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.

66. Primary Care Physician - A physician participating in the TennCare Program who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general

practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

67. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who participates in the TennCare Program and who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

68. Primary Treatment Center (PTC) - A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in state custody, children who have been released from state custody and who have been recommitted, and children who are at imminent risk of entering custody.

69. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.

70. Priority Participants – Individuals who have been classified as CRG 1, 2, or 3 or TPG 2.

For purposes of payment to the BHO, a **Priority Participant** is an individual who is enrolled in the TennCare Program; who has been assessed within the past six months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he is 18 years old or older, or Target Population Group (TPD) 2 if he is under the age of 18; and who has been determined to need services in the **Enhanced Benefits Package**. Designation as a **Priority Participant** expires six months after the assessment has been completed. In order for an individual to remain a **Priority Participant** after the six month period ends, he must be re-assessed as continuing to belong in CRGs 1, 2, or 3 or TPG 2 and the BHO must have provided a service in the **Enhanced Benefits Package** within the past three months. The re-assessment, like the initial assessment, expires after six months unless another assessment is done and the above criteria continue to be met.

For purposes of eligibility for the **Enhanced Benefit Package**, all children under the age of 21 are eligible for medically necessary enhanced benefits in accordance with federal EPSDT requirements. For purposes of eligibility for the **Enhanced Benefits Package**, all adults age 21 and older are eligible for medically necessary enhanced benefits at the time they have been assessed as CRGs 1,2, and 3. Eligibility for **enhanced benefits** shall end only when the adult individual has been re-assessed and found to no longer belong in CRGs 1, 2, or 3, in accordance with Section 2.2.2.2.3.3

71. Priority Population

Adult: An individual age 18 and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

Children and adolescents: Children and adolescents from birth up to age 18 years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the

DSM, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities and includes any mental disorder, regardless of whether it is of biological etiology.

72. Provider- An institution, facility, agency, person, corporation, partnership, or association which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.

73. Provider Agreement or Provider Contract - An agreement between a BHO and a provider of health care services which describes the conditions under which the provider agrees to furnish covered services to the BHO's members.

74. Psychiatric Facility - Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

75. Quality Improvement (QI) - The ongoing process of responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

76. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge

77. Remedial Plan for Children in Custody - The Agreed Order entered into by the state to insure the proper coordination and delivery of health services for children in custody, pursuant to the EPSDT mandate of the Medicaid Act and in accordance with the EPSDT Consent Decree.

78. Seriously Emotionally Disturbed (SED) - Seriously Emotionally Disturbed shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below.

(a) Age from birth to age 18, and

(b) Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV (and subsequent revisions) "V" codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

(c) The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined

as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning score of 50 or less in accordance with the DSM-IV (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

79. <u>Severely and/or Persistently Mentally Ill (SPMI)</u> - Severely and/or Persistently Mentally Ill shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the Clinically Related groups that follow the criteria.

(a) Criteria

1. Age 18 and over; and

2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV (and subsequent revisions) "V" codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and

3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Definition of Clinically Related Groups

1. Clinically Related Group 1. Any person 18 years or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals six months or longer in the past year. This person requires constant assistance or supervision with daily living activities and displays an inability to relate to others which interferes with his/her ability to work and his/her family relationships and usually results in social isolation in the community. Changes in the environment are stressful and may result in further withdrawal or dysfunction in other areas. Support is needed to insure the person's safety and survival.

2. Clinically Related Group 2. Any person 18 years of age or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals less than six months in the past year. This individual has extensive problems with performing daily routine activities and requires frequent assistance. He/She has substantial impairment in his/her ability to take part in social activities or relationships which often results in social isolation in the community. The person has extensive difficulty in adjusting to change. Assistance with activities of daily living is necessary to survival in the community. This person has difficulty completing simple tasks but with assistance could work in a highly supervised setting.

3, Clinically Related Group 3. Any person 18 years of age or older whose functioning has not been severely impaired recently (within the last six months), but has been severely impaired in the past to the extent that he or she needs services to prevent relapse. This individual generally needs long term continued support. Characteristics of this population may include regular or frequent problems with performing daily routine activities. He/She may require some supervision although he/she can survive without it. This person has noticeable disruption in social relations, although he or she is capable of taking part in a variety of social activities. Inadequate social skills have a serious negative impact on the person's life; however, some social roles are maintained with support. This person can complete tasks without prompting and help and can function in the workplace with assistance even though the experience may be stressful. There is sometimes noticeable difficulty in accepting and adjusting to change, and the person may require some intervention.

80. Service Location - Any location at which an enrollee obtains any mental health/substance abuse service covered by the Contractor pursuant to the terms of this CONTRACT.

81. Services - Shall mean the benefits described in Section 2.6, Attachment B, and the Quality of Care Monitors (Attachment C of this CONTRACT).

82. State - State of Tennessee.

83. Subcontract - An agreement entered into by the **Contractor** with any other person or entity which agrees to perform any administrative function or service for the **Contractor** specifically related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT, (e.g., claims processing, marketing, etc.) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the CONTRACT. This definition shall also include any and all agreements between any and all subContractors for the purposes related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT. Agreements to provide covered services as described in Section 2.6 of this CONTRACT shall be considered Provider Agreements and governed by Section 3.9.2 of this CONTRACT.

84. SubContractor - Any organization or person who provides any function or service for the Contractor under a subcontract.

85. Substance Abuse Services - The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

86. TennCare - The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of the TennCare/BHO Agreement and this CONTRACT. Such entity may include, but is not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Developmental Disabilities, and the TennCare Division within the Tennessee Department of Commerce and Insurance and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

87. TennCare/BHO CONTRACT - The agreement entered into between the State of Tennessee and a BHO under the TennCare Program by which a BHO generally receives a capitation payment in return for providing defined health care services to TennCare enrollees.

88. TennCare Program - A program established by the State of Tennessee, consistent with waivers granted by the Health Care Financing Administration within the United States Department of Health and Human Services, whereby the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to MCOs and BHOs for rendering or arranging necessary medical services to persons who are or who would have been Medicaid-eligible under the Medicaid Program as it was administered during Tennessee's fiscal year 1992-93 and non-Medicaid-eligible Tennesseans who are uninsured or who are uninsurable and are enrolled in the TennCare Program.

89. Tennessee Department of Commerce and Insurance (TDCI) - The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

90. Tennessee Department of Health (DOH) - The state agency having the statutory authority to provide for health care needs in Tennessee. For the purposes of this CONTRACT, TDH shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this CONTRACT.

91. Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) Serves as the state's mental health and developmental disability authority and is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities. For the purposes of this CONTRACT, TDMHDD shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this **Contract.**

92. Third Party - Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care of the enrollee.

93. TPG - Target Population Group, A category that includes children and adolescents with serious emotional disturbances.

ATTACHMENT B

COVERED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ATTACHMENT B

Covered Mental Health and Substance Abuse Services

Chart – Basic and Enhanced Benefit Packages

BASIC BENEFITS PACKAGE

Service Type: Psychiatric Inpatient Facility Services

Outpatient Mental Health Services
- M.D. Services
- Non-M.D. Services
- Day Treatment

Pharmacy Services for Psychotropic Medication

Lab Services Related to Psychiatric Needs

Transportation to Covered Mental Health Services

Inpatient Substance Abuse Treatment and Detoxification

Outpatient Substance Abuse Treatment and Detoxification

Specialized Crisis Services
- Mobile Crisis Services
- Specialized Crisis Respite

ENHANCED BENEFITS PACKAGE

Adults

Service Type: All Services in the Basic Mental Health and Substance Abuse Benefits Package listed above

Mental Health Case Management

24 Hour Residential Treatment

Housing/Residential Care
- Supported Housing

Specialized Outpatient and Symptom Management
- M.D. Services
- Non-M.D. Services
- Day Treatment

Psychiatric Rehabilitation and Support Services
- Supported Employment (Site Based/Service Based)

Children and Adolescents

Service Type: All Services in the Basic Mental Health and Substance Abuse Benefits Package listed above

Mental Health Case Management

24 Hour Residential Treatment

Housing/Residential Care

Specialized Outpatient and Symptom Management
- M.D. Services
- Non-M.D. Services
- Day Treatment

Psychiatric Rehabilitation and Support Services

Part 1: Definitions of Covered Mental Health and Substance Abuse Services in the Basic Benefits Package

SERVICE TYPE	**Psychiatric Inpatient Facility Services**

DEFINITION
An inpatient psychiatric facility/unit that offers comprehensive diagnosis, treatment and care to individuals with a mental illness. The focus may be on acute or longer term care and rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

Psychiatric Inpatient Facility Services

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	1 hour (emer invol)/48 hours (invol)/48 hours (vol)

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Discharge
A plan which must be filed with the court, pre-discharge of an individual found not guilty by reason of insanity (NGRI) and not committable. May include court testimony.

48 Hour Evaluation
An evaluation, up to 48 hours, to determine need for treatment, including involuntary commitment.

DCS Transfer Evaluation
An evaluation within five (5) working days of transfer to a regional mental health institute from a DCS institution to determine if the statutory transfer standard was met.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment

An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy

Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Including Chemotherapy for Detoxification Purposes)
Treatment through the use of medications or drugs. May include services provided under a mandatory treatment obligation.

Education (if child)
The provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

ADULT STANDARDS

meets appropriate state licensure
JCAHO accredited
accepts voluntary and involuntary admissions
must comply with TDMHMR Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS

meets appropriate state licensure
JCAHO accredited
accepts voluntary and involuntary admissions
age separated and developmental age appropriate services
must comply with TDMHMR Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
demonstrate ability to link with other mental health providers

SERVICE TYPE	Outpatient Mental Health Services

DEFINITION
This service includes a wide array of outpatient services including, but not limited to intake, evaluation, intervention/therapy, or day treatment. The services can either be based on site or can be delivered off site (any where in the community through the Medicaid rehabilitation option).

ACCESS/AVAILABILITY REQUIREMENTS

M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

NON-M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

DAY TREATMENT

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

OUTPATIENT MENTAL HEALTH SERVICES
M.D. SERVICES/NON-M.D. SERVICES

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Affidavit
A process of filing with a court if an MOT client is non-compliant with, or is in need of renewal, of MOT. May include court testimony.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy

Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Including Chemotherapy for Detoxification Purposes)
Treatment through the use of medications or drugs. May include services provided under a mandatory treatment obligation.

DAY TREATMENT

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination by a physician.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy including for Detoxification Purposes)
Treatment through the use of medications or drugs.

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the general community.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

ADULT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

meets appropriate state licensure
must have 24 hour phone answering and referral
on and off site capability
on-going staff training
demonstrate ability to link with other mental health providers

DAY TREATMENT

must meet appropriate state licensure
on-going staff training
demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

meets appropriate state licensure
must have 24 hour phone answering and referral
on and off site capability
age and developmental age appropriate
on-going staff training
demonstrate ability to link with other mental health providers

DAY TREATMENT

must meet appropriate state licensure
on-going staff training
demonstrate ability to link with other mental health providers
the provision of regular and special education, by TN licensed teachers, in compliance with Minimum Rules and Regulations of the TN Dept. of Education

SERVICE TYPE	Pharmacy Services for Psychotropic Medication

DEFINITION
Psychotropic medication and pharmacy services related to dispensing this medication.

ACCESS/AVAILABILITY REQUIREMENTS

Pharmacy Services for Psychotropic Medication

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 7 calendar days

STANDARDS
must meet appropriate state licensure

SERVICE TYPE	Lab Services Related to Psychiatric Needs

DEFINITION
Lab services related to psychiatric treatment.

ACCESS/AVAILABILITY REQUIREMENTS

Lab Services Related to Psychiatric Needs

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 7 calendar days

STANDARDS
must meet appropriate state licensure

SERVICE TYPE	Transportation to Covered Mental Health Services

DEFINITION
The BHO will, except as otherwise provided in **Standards** below, assure the provision of necessary transportation for eligible recipients to and from providers in order for the eligible recipients to obtain TennCare covered services.

ACCESS/AVAILABILITY REQUIREMENTS

Transportation to Covered Mental Health Services

Geographic Access to the Service Type	Within 30 miles of Participant
Response Time to Contact an Active Client in an Urgent Situation	Within 2 hours
Maximum time for Admission to the Service Type	While a maximum time is not specified for non-emergency transportation, the BHO may recommend that the recipient give the provider a 5 working day notice of their transportation needs whenever possible. Such notice cannot be required, however.

STANDARDS
Transportation services must meet current TennCare standards.

SERVICE TYPE	Inpatient Substance Abuse Treatment and Detoxification

DEFINITION

TREATMENT

A hospital inpatient facility/unit that offers comprehensive substance abuse treatment, detoxification and care.

DETOXIFICATION

Inpatient hospital services for patients who are experiencing or at risk of experiencing a severe withdrawal syndrome or whose treatment needs are complicated by other physical or psychiatric conditions. The goals of this service are to minimize the patient's discomfort and other potential adverse consequences of withdrawal; encouraging the patient to complete detoxification and enter into a rehabilitation program; and, to the extent the patient's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

INPATIENT TREATMENT AND DETOXIFICATION

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 24 hours for detoxification, within 2 calendar days for all other inpatient services.

SERVICE COMPONENTS

TREATMENT

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face with essential others in relation to a specific client.

- **Intervention/Therapy**

DETOXIFICATION

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face with essential others in relation to a specific client.

- **Intervention/Therapy**

STANDARDS

TREATMENT

must meet appropriate state licensure

DETOXIFICATION

must meet appropriate state licensure

SERVICE TYPE	Outpatient Substance Abuse Treatment, and Detoxification

DEFINITION
TREATMENT
This service includes an array of outpatient substance abuse treatment and detoxification services.

DETOXIFICATION
An outpatient service for patients withdrawing from psychoactive substances who are not at risk of a severe withdrawal syndrome or psychiatric destabilization and who live in environments that will not undermine their treatment. The goals of this service are to minimize the patient's discomfort and other potential adverse consequences of withdrawal; encouraging the patient to complete detoxification and enter into a rehabilitation program; and, to the extent the patient's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

OUTPATIENT TREATMENT, AND DETOXIFICATION

Geographic Access to Service Type	Within 30 miles of an individual's home.
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum Time for Admission to Service Type	Within 24 hours for detox, within 3 calendar days for all other outpatient services

SERVICE COMPONENTS
TREATMENT

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

DETOXIFICATION

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

STANDARDS

TREATMENT

- Must meet appropriate state LICENSURE.

DETOXIFICATION

- Must meet appropriate state licensure.
- Patient can not have major psychiatric treatment needs.
- Patient must not be at risk of severe withdrawal syndrome or psychiatric destabilization.
- Patient must live in environments that will not undermine treatment.
- A Tennessee licensed physician must supervise the detoxification process.
- A minimum of daily re-evaluations by a Tennessee licensed physician or registered nurse.
- Client must participate in an outpatient service while they are in the detoxification process.

RECOMMENDED MODELS

TREATMENT

- Day Treatment Rehabilitation (ASAM Level II)
- Day treatment's goals are: to help patients attain the skills necessary to maintain abstinence; resolve problems in family and social relationships caused by or exacerbated by substance abuse; improve medical status; improve functioning at work or at school; eliminate illegal behavior and reduce psychiatric symptoms. Day treatment consists of a minimum of fifteen (15) hours of treatment per week and meets five (5) to seven (7) days per week. Most of the care is delivered in structured groups.
- Intensive Outpatient Rehabilitation (ASAM Level II)

Intensive Outpatient Rehabilitation goals are: to help patients attain the skills necessary to maintain abstinence; resolve problems in family and social relationships caused by or exacerbated by substance abuse; improve medical status; improve functioning at work or at school; eliminate illegal behavior and reduce psychiatric symptoms. Intensive Outpatient Rehabilitation consists of a minimum of three (3) hours of treatment per day, three (3) to five (5) days per week. Most of the care is delivered in structured groups.

- Outpatient Services (ASAM Level I)

  Outpatient services are individual, family, and group therapy services for patients whose substance abuse problems are of relatively short duration and who have experienced only mild to moderate impairment in family and social relationships, health, mental condition, employment, education, or ability to refrain from illegal activity, or for patients who are in need of step-down treatment at a less restrictive level. The goals may be either long-term abstinence or, for adults, a period of abstinence followed by responsible alcohol use, depending on the needs of the patient. Other goals include resolution of relationship, health, mental health, employment, education, and legal problems that are associated with substance abuse. Most outpatient care is delivered in weekly group, individual or family sessions.

Part 2: Definitions of Covered Services in the Enhanced Benefits Packages (Adults)

SERVICE TYPE	**Mental Health Case Management ADULT**

DEFINITION

A series of actions taken by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring that the consumer/family accesses services. Mental health case management requires the mental health case manager and consumer/family to have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Mental health case management is provided in community settings which are accessible and comfortable to the consumer/family. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Adult

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Assessment**

Mental Health Case Management Assessment

An assessment including but not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation. Assessment activities include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the client's progress with goals and choices on an ongoing basis is also considered an assessment activity. Assessment, therefore is not limited to a formal process.

CRG Assessment

An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment

An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

- **Service Plan**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the client and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face with essential others in relation to a specific client.

- **Crisis Assistance**

Crisis assistance and intervention are services which are provided in situations requiring immediate attention/ resolution for a specific client or other person(s) in relation to a specific client. Provides the initial intervention in crisis situations and coordinates the provision of other needed crisis services. Most crisis intervention activities would involve face to face contact with the client. However, a face to face crisis intervention with a family member only, in relation to a specific client, would be considered crisis assistance

- **Daily Living Assistance**

The on-going monitoring of how a client is coping with life on a day to day basis which includes face to face contact with the client or essential others on behalf of a specific client. Examples include, home visits, shopping, medication monitoring, learning to ride the bus, monitoring/educating about health maintenance, on-going contact with family members, etc. Staff helps carry out activities in a role model function in the client's natural environment.

- **Linkage/Referral/Advocacy**

Accessing and mobilizing resources to meet the needs of a specific client. Often this will include being an advocate or representing a person who otherwise could not negotiate or access complex systems without assistance and support.

- **Independent Living Support/Wrap Around**

Funds available to the mental health case manager on behalf of any person (adult or child/adolescent) receiving mental health case management services. These funds are to be used to acquire items or services that will assist the client to live independent of institutional settings, or to continue to live in the community, and shall be related to the goals set forth in the mental health case management service plan.

- **Liaison**

Mental health case management activity which offers to persons who are not yet assigned but who are eligible, for mental health case management, short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

ADULT STANDARDS

meets appropriate state licensure
24 hour, 365 days a year service
90% of service occurs off-site, in person
provides continuity of services, including mental health case management
agency weighted average caseload not to exceed 30
face to face contact at least 1 time/month

RECOMMENDED MODELS

- **Continuous Treatment Teams**

An intensive form of case management which includes a coordinated group of staff members that provide a range of clinical treatment, rehabilitation and support services 24 hours per day to ensure ongoing therapeutic involvement of the individual in the program. The Team must include psychiatric, nursing and case management staff. The continuous treatment team provides medications assessment and medication monitoring.

- **Team Mental Health Case Management**

An arrangement of case management which allows for the collaboration of a group of case managers serving an identified group of consumers. This approach offers consumer a wider base of support and services.

- **Specialized Mental Health Case Management Team**

Case management which is organized around a specialty population such as geriatric, homeless, dually diagnosed.

SERVICE TYPE	24-Hour Residential Treatment Adult

DEFINITION
Community based facility that offers 24 hour residential care as well as treatment and rehabilitation. The focus may be on short term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - ADULT

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not Applicable
Maximum time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the level of social functioning of an individual, including such things as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relation-ship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy including for Detoxification Purposes)
Treatment through the use of medications or drugs. [Methadone treatment is covered under Substance Abuse Services.]

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the normal community.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

ADULT STANDARDS

meets appropriate state licensure and local housing codes
on-going staff training required

SERVICE TYPE	Housing/Residential Care ADULT

DEFINITION

Supported Housing

The category refers to facilities staffed twenty-four (24) hours per day (not residential treatment facilities) for persons with serious and persistent mental illness and have associated mental health staff support. Residential Care is intended to prepare individuals for more independent living in the community while providing an environment that allows an individual to live in the community with appropriate mental health supports.

Housing Specialist

This service is provided by a housing specialist who is knowledgeable in federal, state and local housing resources. The service develops and maintains housing options for individuals with a serious mental illness.

ACCESS/AVAILABILITY REQUIREMENTS

Supported Housing

Geographic Access to the Service Type	Based upon Consumer Choice. Must maintain access as specified in the TENNCARE-BHO Agreement (60 miles).
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

SUPPORTED HOUSING

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Assessment**

The determination of an individual's current and potential strengths, resources and needs through formal and informal assessment.

- **Service Plan (if child)**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify services and assistance necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the consumer and/or face to face, with essential others in relation to a specific consumer.

- **Housing Site**

The actual residence of an individual while receiving this service.

- **Staff Support**
  - On or off site assistance provided by a mental health staff member to an individual living in community housing.
  - Referral and linkage

Housing Specialist

Intake

The process of gathering information needed to screen for and/or initiate service

Assessment

The determination of an individual's current and potential strengths, resources and needs through formal and informal assessment.

Housing Broker

Activities related to locating existing housing, identifying availability of housing and matching an individual with available housing.

Placement Activities

Activities related to assisting an individual with the arrangements necessary to secure an identified housing site.

Housing Development

Activities related to the initiation and development of new housing, utilizing private local, state, and/or federal resources. Emphasis is on the resource development which parallels the community at large.

Community Education/Advocacy

Educational and advocacy activities related to identifying service needs.

ADULT STANDARDS

Supported Housing

meets appropriate state licensure and local codes
24 hour staff support, on or off site
housing is safe and affordable to consumer
consumer choice regarding location
on-going staff training
demonstrate ability to link with other mental health providers

Housing Specialist

- resource base is comparable to community at large
- housing is affordable to consumer
- consumer choice regarding location
- on-going staff training
- demonstrate ability to link with other mental health providers
- annual report

RECOMMENDED MODELS

- **Supported Housing**

Supportive Apartment

A housing arrangement which provides mental health staff support to independent apartments or group living settings for consumers who choose and benefit from group living. This model allows a consumer to live independently yet have a defined mental health support system.

Supportive Living Facility (staffed by mental health staff)

A licensed housing model which provides 24 hour on-site mental health staff support when residents are on-site.

Consumer Managed Housing
A housing model which provides support and management from an on-site peer. The consumer manager has direct support from mental health staff.

- **Housing Specialist**

Housing Developer
A designated housing specialist who is knowledgeable in federal, state and local housing resources. Develops and maintains housing options for individuals being discharged from this service. Provides linkage to federal, state and local resources. The service develops and maintains housing options for individuals with a serious mental illness.

SERVICE TYPE	Specialized Outpatient and Symptom Management ADULT

DEFINITION
This service includes a wide array of outpatient services including, but not limited to intake, evaluation, intervention/therapy, or day treatment. The services can either be based on site or can be delivered off site (any where in the community through the Medicaid rehabilitation option).

ACCESS/AVAILABILITY REQUIREMENTS

M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

NON-M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

DAY TREATMENT

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

M.D. SERVICES and NON-M.D. SERVICES

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Affidavit
A process of filing with a court if an MOT client is non-compliant with, or is in need of renewal, of MOT. May include court testimony.

Psychological Evaluation

An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment

An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment

An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation

A medical/physical examination.

Educational Evaluation

An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation

An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation

An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS

An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy

Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation (MOT).

Group Intervention/Therapy

Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation (MOT).

Family Intervention/Therapy

Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy

Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy for Detoxification Purposes)
Treatment through the use of medications or drugs except methadone. May include services provided under a mandatory treatment obligation (MOT).

DAY TREATMENT

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination by a physician

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy including for Detoxification Purposes)
Treatment through the use of medications or drugs.

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the normal community.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

ADULT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

meets appropriate state licensure
must have 24 hour phone answering and referral
on and off site capability
on-going staff training
demonstrate ability to link with other mental health providers

DAY TREATMENT

must meet appropriate state licensure
on-going staff training
demonstrate ability to link with other mental health providers

RECOMMENDED MODELS

M.D. SERVICES and NON-M.D. SERVICES

DAY TREATMENT

SERVICE TYPE	Specialized Crisis Services ADULT

DEFINITION

Mobile Crisis Services

Crisis services provides 24-hour telephone lines for crisis intervention, and mobile crisis intervention and resolution teams. Mobile crisis teams provide outreach-oriented crisis response and resolution services for individuals, particularly at times when case managers are less available. For admission to Regional Mental Health Institutes, the teams are designed to perform the functions of mandatory prescreening in accordance with T.C.A. 33-2-601-604 to ensure an effective inpatient diversion system and maintain the individual in the least restrictive environment as appropriate.

Specialized Crisis Respite - Adults

Respite services are a function of the Crisis Response Team (CRT). Services are intended to provide a safe environment and staff support for individuals who cannot stay in their homes during a crisis, and who otherwise might be hospitalized. Adult respite services should be encouraged to employ consumers as respite care staff members. Respite services must utilize appropriate unique local and regional approaches. These might include foster family-like placements, a bed in a board and care home or hotel/motel room, or support for a volunteer-staffed respite apartment.

ACCESS/AVAILABILITY REQUIREMENTS

MOBILE CRISIS SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 1 hour
Maximum time for Admission to the Service Type	Within 1 hour

SPECIALIZED CRISIS RESPITE

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Immediate
Maximum time for Admission to the Service Type	Within 2 hours

SERVICE COMPONENTS

Mobile Crisis Services

Screening for hospitalization

A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines whether the consumer **does meet** the criteria for admission to an inpatient psychiatric facility and that there are no less drastic alternative available.

Crisis Intervention

A face-to-face intervention between the crisis staff and the consumer and/or significant other(s). The intervention is delivered where the consumer is experiencing the crisis and is intended to stabilize the individual to prevent the crisis from escalating.

Follow Up

A face-to-face session between the consumer and the crisis staff following the crisis intervention session. This could be a daily session for several days or once a week until the consumer can be seen in another service. Follow-up visits are to ensure the consumer is stable and has regained control of the crisis situation.

Telephone Intervention
A phone intervention between the crisis staff and the consumer and/or significant other(s). The intervention is intended to assess the need for mobile crisis response or referral to the appropriate resource if mobile response is not necessary in order to stabilize the individual in order to prevent the crisis from escalating.

Mandatory Pre-screening to RMHI
A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines that the consumer **does meet** the criteria for admission to the RMHI and that there are no less drastic alternative available.

Specialized Crisis Respite
Respite Plan
An individualized plan of action which is developed and agreed upon by the crisis response service, the client, the respite companion and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Respite location
The community location where respite service is being provided.

Respite staff
Trained staff who remain with a client continually during a respite episode.

ADULT STANDARDS

MOBILE CRISIS SERVICES
must meet appropriate state licensure
service offered 365 days a year
90% of face to face contacts occur off site
of off-site, no more than 50% at ER/jails
one published toll-free phone number per CSA region
24 hour service (phone and in person)
mental health staffed telephone line
on-going staff training
demonstrate ability to link with other mental health providers
for RMHI admissions, able to complete mandatory prescreening activities
through mobile crisis staff trained and designated by TENNCARE

SPECIALIZED CRISIS RESPITE
must meet appropriate state licensure
services offered 365 days a year, 24 hours a day
encourage use of consumers/families as respite workers
continuous respite staff provided to those in respite
respite location includes room and board
referral must come from specialized crisis team and must include 24 hour
crisis team back-up
on-going staff training

RECOMMENDED MODELS

MOBILE CRISIS SERVICES

SPECIALIZED CRISIS RESPITE

SERVICE TYPE	Psychiatric Rehabilitation and *Support Services* ADULT

DEFINITION

Psychiatric Rehabilitation And Support Services

Planned interventions conducted by mental health staff or others in response to a diagnosed mental health problem. These services are designed to ensure that an individual receives services in the least restrictive environment necessary to achieve successful results, improve quality of life and prevent mental health crisis. This definition assumes that in order to successfully address an individual's mental illness, other facets of the individual's being must also be considered.

Supported Employment

This consists of a range of services to assist consumers to prepare for, obtain, and maintain employment. This service also includes a variety of support services to the consumer, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Consultation and Education

This service provides information, counseling, behavior management training and early intervention strategies pertaining to childhood mental illness. This service enables school teachers, counselors and others to be sensitive to early signs of mental illness and to intervene e before a crisis develops.

Social

These services are consumer family based and operated providing self-help skills. Services are often provided during the evening and weekend hours

ACCESS/AVAILABILITY REQUIREMENTS

SUPPORTED EMPLOYMENT (SITE BASED/SERVICE BASED)

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

SUPPORTED EMPLOYMENT (SITE BASED/SERVICE BASED)

- **Intake**

The process of gathering information needed to screen for and/or initiate service

- **Assessment**

Educational Evaluation

An evaluation to determine academic interest aptitudes, and achievements.

Vocational and Work Evaluation

An evaluation to determine vocational interests, aptitudes, and achievements.

- **Service Plan**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the client and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Enclave**

A work unit provided by a licensed vocational program consisting of two (2) or more individuals with a severe and/ or persistent mental illness working in normal, competitive work setting. The setting focuses on assessment, training and work experience with pay.

- **Social Support Services**

Group and individual activities or programs provided in a low demand supportive employment. The service is non-clinical and is not meant to provide a treatment intervention. The service promotes peer support and socialization. The service might also provide an individual client with assistance in the use of community resources and might refer and link the client to the appropriate service.

- **Pre-vocational Work Units**

A structured work environment or program provided by the agency that focuses on assessment, training and work experience. The setting is located at the agency.

- **Interpersonal Skills Training**

Training in communication, decision making, problem solving, relationship building, peer support, self responsibility and self advocacy.

- **Daily Living Sills**

Teaching the skill **in the place** where the skill to be used as opposed to teaching the skill in the program site. Skills taught include budgeting, nutrition, safety, banking, self medication, shopping, use of transportation, etc.

- **Leisure Skills Training**

Assisting clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the normal community.

- **Educational Development**

Linking the client to basic adult education opportunities in the community.

- **Self Help Groups**

Client run groups to provide companionship, mutual support and self advocacy.

- **Family Involvement**

Reinforcement and encouragement of family members as natural support systems. Family education in crisis management, psychopharmocology and community resources. Skills are learned via staff and client participating together and mutually sharing the activity. The staff serve in the role model function by working on a task side by side with the client.

- **Pre-vocational Job Readiness**

Initial contacts between the job coach and the client to help the client develop choices about employment and select the types of jobs preferred are considered supportive employment sessions.

- **Job Coaching**

Actual on the job training of the client by the staff member or "job coaching" by the staff member to help the client learn and practice the skill necessary to perform in either a temporary position or in a competitive job and may include orientation to the work culture. Job training or coaching may last several hours a day over a period of time until the client is ready to work the job without a job coach.

- **Development of Job Sites**

Activities related to the initiation and development of new employment resources, utilizing private, local, state, and/ or federal resources. Emphasis is on the resource development which parallels the community at large.

- **Job Placement**

Activities which match employer and employee needs to a particular job.

- **Employer Support**

Contact with the Employer/Supervisor is made in relation to a specific client's job performance from the employer's perspective. May also include educating the employer in providing job coaching assistance to the client, restricted to activities directly related to the client's job performed by a staff member whose major responsibilities are supported employment work functions.

- **Community Education/Advocacy**

Educational and advocacy activities related to identifying service needs.

ADULT STANDARDS

SUPPORTED EMPLOYMENT (SITE BASED/SERVICE BASED)

must meet appropriate state licensure
at least 85% of jobs are jobs which exist normally in the community
consumers must have realistic transportation plans
on-going staff training
demonstrate ability to link with other mental health providers

RECOMMENDED MODELS

SUPPORTED EMPLOYMENT (SITE BASED/SERVICE BASED)

Employment Specialist. This consists of a range of services to assist consumers to prepare for, obtain and maintain employment. Services include vocational assessment and counseling, pre-vocational job readiness, career development, job development, on-the-job training, and support provided to the consumer as well as the employer. This service also includes a variety of support services to the side-by-side support on the job. These services may be integrated into the Continuous Treatment Teams or the psychosocial rehabilitation center for maximum coordination.

PSYCHOSOCIAL REHABILITATION CENTER

This service consists of vocational and socialization services that include strong involvement in service planning and service implementation by clients or members. Vocational services provided include participation in activities to operate the center, as well as transitional and supported employment services to assist the consumer in obtaining gainful employment in the community, and on-the-job staff support for the members and the employer. A variation of these services includes five-person rehabilitation teams. These teams have the capacity to provide rehabilitation services in a person's own home, in the community or work site, to increase skills in daily living activities, such as housekeeping, meals, grooming and hygiene, use of transportation, shopping, budgeting, and so forth. These rehabilitation workers are expected to work closely with case managers, distinct from the psychosocial centers.

Part 3: Definitions of Covered Services in the Enhanced Benefits Package (Children & Adolescents)

SERVICE TYPE	**Mental Health Case Management CHILDREN AND ADOLESCENTS**

DEFINITION

A series of actions taken by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring that the consumer/family accesses services. Mental health case management requires the mental health case manager and consumer/family to have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Mental health case management is provided in community settings which are accessible and comfortable to the consumer/family. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Children and Adolescents

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 2 hours
Maximum time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Assessment**

Mental Health Case Management Assessment

An assessment including but not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation. Assessment activities include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the client's progress with goals and choices on an ongoing basis is also considered an assessment activity. Assessment, therefore is not limited to a formal process.

CRG Assessment

An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment

An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

- **Service Plan**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the client and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Crisis Assistance**

Crisis assistance and intervention are services which are provided in situations requiring immediate attention/ resolution for a specific client or other person(s) in relation to a specific client. Provides the initial intervention in crisis situations and coordinates the provision of other needed crisis services. Most crisis intervention activities would involve face to face contact with the client. However, a face to face crisis intervention with a family member only, in relation to a specific client, would be considered crisis assistance.

- **Daily Living Assistance**

The on-going monitoring of how a client is coping with life on a day to day basis which includes face to face contact with the client or essential others on behalf of a specific client. Examples include, home visits, shopping, medication monitoring, learning to ride the bus, monitoring/educating about health maintenance, on-going contact with family members, etc. next category. Staff helps carry out activities in a role model function in the client's natural environment.

- **Linkage/Referral/Advocacy**

Accessing and mobilizing resources to meet the needs of a specific client. Often this will include being an advocate or representing a person who otherwise could not negotiate or access complex systems without assistance and support.

- **Independent Living Support/Wrap Around**

Funds available to the mental health case manager on behalf of any person (adult or child/adolescent) receiving mental health case management services. These funds are to be used to acquire items or services that will assist the client to live independent of institutional settings, or to continue to live in the community, and shall be related to the goals set forth in the mental health case management service plan.

- **Liaison**

Mental health case management activity which offers to persons who are not yet assigned but who are eligible, for mental health case management, short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

CHILDREN AND ADOLESCENT STANDARDS

meets appropriate state licensure
24 hour, 365 days a year service
90% of service occurs off site, in person
provides continuity of services, including case management
agency weighted average caseload not to exceed 18
face to face contact at least 1 time/month

RECOMMENDED MODELS

- **Targeted Mental Health Case Management**

Targeted case management is an intensive form of case management which usually requires as much as 2 to 4 face to face contacts per week for the first month. The case manager is often required to do face to face active advocacy for the child with the school and other community agencies so that the child is able to obtain needed services. Intensive case management is usually the last effort to keep the child at home and out of hospital or residential placement.

- **Case Coordination**

A model of case management that provides short-term crisis consultation and advocacy. The case coordinator does not carry an on-going caseload. The case manager provides intense liaison services at a systems level.

SERVICE TYPE	24 Hour Residential Treatment CHILDREN AND ADOLESCENT

DEFINITION
Community based facility that offers 24 hour residential care as well as treatment and rehabilitation. The focus may be on short term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - Children and Adolescents

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not Applicable
Maximum time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the level of social functioning of an individual, including such things as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Methadone and Detoxification Purposes)
Treatment through the use of medications or drugs except methadone.

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the normal community.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

CHILDREN AND ADOLESCENT STANDARDS

meets appropriate state licensure and local housing codes
age separated and developmental age appropriate services
on-going staff training required
the provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

RECOMMENDED MODELS

- **Diagnostic and Evaluation Shelters**

D&E Shelter is a short term staff-secure residential placement in a community setting for the purpose of evaluating a youth who cannot be evaluated as an outpatient, but who does not require the degree of medical attention provided in a hospital setting. These placements are fifteen-day periods, twenty-four hours per day, and include the following services: routine physical and mental health care, education and recreation services, non-medical crisis response such as counseling and behavioral intervention. The educational component must be approved by the State Department of Education.

- **Therapeutic Foster Care**

This service involves provision of approved families specially trained in mental health issues, and willing to work with children for whom regular foster homes have not been successful. This model involves serving a limited number of children with intensive mental health staff support.

- **Specialized Residential Treatment Facility**

This is highly structured staff secure community based 24 hour residential treatment for children and youth with specialized sub-population of children and adolescents with serious emotional disturbance who do not require the medical intensity of a hospital placement but who need far more structure and intense treatment than that provided by outpatient services, day program, or other less restrictive settings. Education may be provided on site or through the local public school system.

- **Independent Living (Children and Adolescents)**

This service or program is oriented toward the acquisition of independent lifestyles for adolescents aged 17-21. This program provides for living in an apartment setting with counselors on site. Services include counseling, recreation, transportation, vocational training, job supervision, as well as skills training in activities of daily living, and in social and family skills.

- **Crisis Nursery**

A service which provides temporary emergency services and care for children. These child care facilities protect children by providing a safe environment at a time when the chances of neglect or abuse in the home are increased. The program provides training for parents, takes measures to reduce the incidence of child abuse in families served in the program, and makes referrals for needed social services.

SERVICE TYPE	Housing/Residential Care CHILDREN AND ADOLESCENT

DEFINITION

- **Supported Housing**

The category refers to facilities which are staffed twenty-four (24) hours per day (not residential treatment facilities) or other types of congregate living for seriously and persistently mentally ill adults, or children and youth with a serious emotional disturbance, that has associated mental health staff support. Homes are intended to either prepare individuals for more independent living in the community or provide an environment that allows an individual to live in the community. Some homes provide mental health training and support.

NOTE: HOUSING/RESIDENTIAL CARE SERVICES (EXCLUDING 24 HOUR RESIDENTIAL TREATMENT FACILITIES) DO NOT APPLY TO CHILDREN AND ADOLESCENTS.

SERVICE TYPE	Specialized Outpatient and Symptom Management CHILDREN AND ADOLESCENT

DEFINITION

This service includes a wide array of outpatient services including, but not limited to intake, evaluation, intervention/therapy, or day treatment. The services can either be based on site or can be delivered off site (any where in the community through the Medicaid rehabilitation option).

ACCESS/AVAILABILITY REQUIREMENTS

M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

NON-M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

DAY TREATMENT

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

M.D. SERVICES and NON-M.D. SERVICES

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation

A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation

An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Affidavit

A process of filing with a court if an MOT client is non-compliant with, or is in need of renewal, of MOT. May include court testimony.

Psychological Evaluation

An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation (MOT)

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation (MOT)

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)
Collateral Intervention/Therapy

Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy for Detoxification Purposes)
Treatment through the use of medications or drugs. May include services provided under a mandatory treatment obligation (MOT).

DAY TREATMENT

- **Intake**

The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination by a physician

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the client and/ or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
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Medication (Chemotherapy Except for Methadone and Detoxification Purposes)
Treatment through the use of medications or drugs except methadone.

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the normal community.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

CHILDREN AND ADOLESCENT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

meets appropriate state licensure
must have 24 hour phone answering and referral
on and off site capability
age and developmental age appropriate
on-going staff training
demonstrate ability to link with other mental health providers
able to provide services under T.C.A. Chapter 33

DAY TREATMENT

must meet appropriate state licensure
on-going staff training
demonstrate ability to link with other mental health providers
the provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

RECOMMENDED MODELS

NON-M.D. SERVICES

R.I.P.

RIP is a program designed for the early treatment of children with moderate to severe behavior disorders. RIP enrollment is available to families with children who have not yet entered first grade. At least one parent (or other adult) and one child from each enrolled family are required to participate in the program a minimum of two times per week. Supported by a small professional and paraprofessional staff, parents serve as primary teachers and therapists for their own child, as daily operators of the overall program, and as primary sources of assistance and outcome-based management by objectives system. Enrollment is divided into two phases: The treatment phase and the payback phase. Program activities are organized within a system of modules that includes: behavioral skills training, developmental skills training, social skills training, RIP preschool classrooms, and community preschool intervention.

Family Preservation

A behaviorally oriented, intensive short-term, in-home crisis intervention and family education service which includes counseling, advocacy, parent education and training, 24 hour accessibility of staff for crisis response.

In Home Alternatives to Hospitalization

This services is available 24 hours, 7 days a week and is delivered in a child's home by a multi-disciplinary team of mental health professionals including medical staff to provide treatment, crisis response, parent support and training, family therapy. It is expected that if this service was not available, the child would be placed in a hospital for treatment.

DAY TREATMENT

- **Day Treatment.**

Intensive day treatment programs combine education, mental health treatment, and family support services to children who, because of the severity of their problems, cannot succeed in regular or special educational environments. Sites may be school based or elsewhere in the community.

- **Therapeutic Nursery**

Therapeutic Nurseries are designed for preschool children, ages two through six, who are abused or neglected or are at risk of abuse or neglect, and who are experiencing emotional disturbance. The purpose of the program is to provide early intervention in order to remediate present difficulties and prevent future psychiatric hospitalization. Several treatment components are provided in order to achieve this goal, including individualized behavior modification programs for each child, remediation of specific developmental difficulties, and where necessary, individual therapy for each child, and intervention with the child's parent(s).

- **Infant Stimulation**

The purpose of this model to prevent child abuse and neglect for children ages two through five years of age. Their parents receive early intervention in basic parenting skills and have been identified as a "high risk to abuse." The program format includes infant stimulation, parent training through modeling, demonstration, implementation, and direct feedback in a group setting and in the homes of clients. Parents are helped to implement parenting skills related to the child's cognitive, language, and emotional status.

SERVICE TYPE	Specialized Crisis Services CHILDREN AND ADOLESCENTS

DEFINITION

Mobile Crisis Services.

Crisis services provides 24-hour telephone lines for crisis intervention, and mobile crisis intervention and resolution teams. Mobile crisis teams provide outreach-oriented crisis response and resolution services for individuals, particularly at times when case managers are less available. For admission to Regional Mental Health Institutes, the teams are designed to perform the functions of mandatory prescreening in accordance with T.C.A. 33-2-601-604 to ensure an effective inpatient diversion system and maintain the individual in the least restrictive environment as appropriate.

Crisis Respite - C&A

Crisis Respite services are available on a 24 hour basis to provide immediate shelter and nurturance to those children whose families are in need of emergency respite. Crisis respite services must utilize appropriate local approaches. These might include facility based, home based or a hotel room with a respite aide. Any local approach to crisis respite involves short term extended respite with overnight capacity and is designed to provide shelter, while dealing with the child's behaviors during the time of crisis. For children and adolescents, parental authorization or court order must accompany crisis respite.

ACCESS/AVAILABILITY REQUIREMENTS

Mobile Crisis Services

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 1 hour
Maximum time for Admission to the Service Type	Within 1 hour

Crisis Respite

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 1 hour
Maximum time for Admission to the Service Type	Within 2 hours

SERVICE COMPONENTS

- **Mobile Crisis Services**

Screening for hospitalization

A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines whether the consumer **does meet** the criteria for admission to an inpatient psychiatric facility and that there are no less drastic alternative available.

Crisis Intervention

A face-to-face intervention between the crisis staff and the consumer and/or significant other(s). The intervention is delivered where the consumer is experiencing the crisis and is intended to stabilize the individual to prevent the crisis from escalating.

Follow Up

A face-to-face face session between the consumer and the crisis staff following the crisis intervention session. This could be a daily session for several days or once a week until the consumer can be seen in another service. Follow-up visits are to ensure the consumer is stable and has regained control of the crisis situation.

Telephone Intervention

A phone intervention between the crisis staff and the consumer and/or significant other(s). The intervention is intended to assess the need for mobile crisis response or referral to the appropriate resource if mobile response is not necessary in order to stabilize the individual in order to prevent the crisis from escalating.

Mandatory Pre-screening to RMHI
A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines that the consumer **does meet** the criteria for admission to the RMHI and that there are no less drastic alternative available.

- **Specialized Crisis Respite**

Respite Plan
An individualized plan of action which is developed and agreed upon by the crisis response service, the client, the respite companion and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Respite location
The community location where respite service is being provided.

Respite staff
Trained staff who remain with a client continually during a respite episode.

CHILDREN AND ADOLESCENT STANDARDS

Mobile Crisis Services

must meet appropriate state licensure
service offered 365 days a year
90% of face to face contacts occur off site
of off-site, no more than 50% at ER/jails
one published toll-free phone number per CSA region
24 hour service (phone and in person)
mental health staffed telephone line
on-going staff training
demonstrate ability to link with other mental health providers
for RMHI admissions, able to complete mandatory prescreening activities through mobile crisis staff trained and designated by TENNCARE

Specialized Crisis Respite

must meet appropriate state licensure
services offered 365 days a year
on-going staff training
referral must come from specialized crisis team and must include 24 hour crisis team back-up
respite location includes room and board
continuous respite staff provided to those in respite

RECOMMENDED MODELS

MOBILE CRISIS SERVICES

SPECIALIZED CRISIS RESPITE

- **Emergency Shelter**

Emergency Shelter is short term and is designed to provide shelter for children during the time of crisis. This service is available on a 24-hour basis to provide immediate shelter and nurturance to those children who are removed from their homes or from other settings. Emergency support in the form of counseling and assessment and room and board are provided until the crisis is resolved or a more permanent placement is found. Must be licensed by the state.

- **Emergency Foster Care**

This service is distinguished from emergency shelter in that the former is usually provided by an agency and the latter is provided by a family in the community. Must be licensed by the state.

SERVICE TYPE	Psychiatric Rehabilitation and *Support Services* CHILDREN AND ADOLESCENT

DEFINITION

Psychiatric Rehabilitation And Support Services

Planned interventions conducted by mental health staff or others in response to a diagnosed mental health problem. These services are designed to ensure that an individual receives service in the least restrictive environment necessary to achieve successful results, improve quality of life and prevent mental health crisis. This definition assumes that in order to successfully address an individual's mental illness, other facets of the individual's being must also be considered.

Supported Employment.

This consists of a range of services to assist consumers to prepare for, obtain, and maintain employment. This service also includes a variety of support services to the consumer, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Consultation And Education

This service provides information, counseling, behavior management training and early intervention strategies pertaining to childhood mental illness. This service enables school teachers, counselors and others to be sensitive to early signs of mental illness and to intervene before a crisis develops.

Social.

These services are consumer family based and operated providing self-help skills. Services are often provided during the evening and weekend hours

ACCESS/AVAILABILITY REQUIREMENTS

Psychiatric Rehabilitation and Support Services - Children and Adolescents

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours
Maximum time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

NOTE: SUPPORTED EMPLOYMENT SERVICES FOR CHILDREN AND ADOLESCENTS ARE DELIVERED THROUGH 24 RESIDENTIAL TREATMENT FACILITIES AND SPECIALIZED OUTPATIENT AND SYMPTOM MANAGEMENT SERVICES (DAY SERVICES).

ATTACHMENT C

STANDARDS FOR BHO QUALITY MONITORING PROGRAMS

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Standards for Internal Quality Monitoring Programs of Behavioral Health Organizations Contracting with the Tennessee Department of Mental Health and Mental Retardation

STANDARDS FOR INTERNAL QUALITY MONITORING PROGRAMS OF BEHAVIORAL HEALTH ORGANIZATIONS CONTRACTING WITH THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

A Behavioral Health Organization (BHO) which contracts with the Tennessee Department of Mental Health and Mental Retardation (DMHMR) to provide TennCare-funded mental health services will have in place an internal quality monitoring system. The internal quality monitoring program (QMP) will consist of systematic activities undertaken by the BHO to monitor and evaluate the services delivered to its enrollees. The evaluation will be based on predetermined, objective standards. Its primary purpose is to assure and to continually improve the quality of mental health and substance abuse services provided.

The BHO's quality monitoring program is to be evaluated using the following standards. The BHO will submit a written description of its QMP to DMHMR for approval.

The guidelines were developed using DMHMR standards and the Tennessee Department of Health's Bureau of Alcohol and Drug Abuse Services and were patterned after TennCare's requirements for an internal quality monitoring program. Guidelines were also derived from these sources:

> Purchasing Managed Care Services for Alcohol and Other Drug Treatment, SAMHSA/CSAT, 1995;
>
> The National Committee for Quality Assurance (NCQA) Quality Assurance Standards, dated July 27, 1991;
>
> The National Association of HMO Regulators/National Association of Insurance Commissioners' Recommended Operational Requirements for HMO Quality Assurance Programs, adopted by the NAIC/NAHMOR Joint Task Force, December 1988; and
>
> The HCFA Office of Prepaid Health Care's Quality Assurance Standards for HMOs and CMPs Contraction with the Medicare Program, dated November 1989;

as detailed in "A Health Care Quality Improvement System for Medicaid Coordinated Care", U.S. Department of Health and Human Services, Health Care Financing Administration Medicaid Bureau, December 23, 1992.

DMHMR will monitor the BHO's compliance with the standards governing the organization's QMP.

QMP STANDARDS

Standard I: The organization has a written description of its QMP. The written description includes:

A. Goals and Objectives: The written description contains comprehensive quality assurance/improvement goals and objectives which are developed initially, reviewed annually, and revised as needed. Included is a timetable for implementation and accomplishment of objectives. Objectives must be specific and measurable.

B. Scope:

1. The scope of the QMP is comprehensive, addressing both the quality of mental health and substance abuse services provided and the quality of non-clinical aspects of care such as competency of care, awareness, availability, accessibility, consumer family involvement, coordination, continuity of care, basic rights, confidentiality and cultural sensitivity.

2. The QMP methodology provides for a review of the entire range of mental health and substance abuse services provided by assuring that all demographic groups, clinically related/target population groups, non-target population groups, service settings (e.g., inpatient, clinic, off-site/home), and types of services (e.g., mental health case management, residential treatment, partial hospitalization, housing/ residential care, outpatient, and symptom management, specialized crisis services, and psychiatric rehabilitation and support services) are involved in the scope of the review.

C. Specific Activities: The written description specifies the quality of services studies and other activities to be undertaken over a prescribed period of time and the methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity: The written description provides for continuous performance of quality assurance/improvement activities, including tracking of issues over time.

E. Provider Review: The QMP provides for:

1. Peer review by appropriate types of mental health and substance abuse care professionals of the processes followed in the provision of each different type of mental health and substance abuse service [e.g., reviewers of psychosocial services should include a provider(s) of psychosocial services]; and

2. Feedback to provider organizations, to mental health care and substance abuse professionals, and to BHO staff regarding performance and consumer outcomes.

F. Focus on Outcomes: The QMP methodology addresses the mental health and substance abuse outcomes identified by DMHMR and any other outcomes identified by the BHO.

G. Systematic Process of Quality Assurance and Improvement: The QMP objectively and systematically monitors and evaluates the quality and appropriateness of services provided to its members and pursues opportunities for improvement on an ongoing basis.

1. The QMP has written descriptions of the processes for monitoring and evaluating the following which include the data to be collected and how data are to be analyzed and trended. For *f.* through *j.* below, the BHO will report its findings to DMHMR on an annual basis.

    a. Utilization management based on criteria set forth by DMHMR.

    b. Compliance with standards set by DMHMR (including those set forth in this document, those referenced by this document, those referenced by the contract, and licensure standards);

    c. Measurement of performance as prescribed by DMHMR;

    e. Use of clinical care standards/"best practice" guidelines which have been approved by DMHMR;

    f. Service denials by the BHO;

    g. Formulary denials by the BHO;

    h. Inpatient psychiatric hospital admissions and readmissions;

    i. Satisfaction of consumers and families with the service provided; and

    j. Network provider satisfaction.

2. As part of the quality assurance and improvement process, cross functional teams should be established. The team's purpose would be to identify areas where improvements are needed, establish the cause of the problem, develop and implement an improved process, assess its impact and, if needed, adjust or modify the process. This approach follows the Plan-Do-Check-Act (PDCA) cycle and is presented in condensed form below.

    a. Identify and analyze the problem: The problem statement should clearly reveal the discrepancy between what is expected and what is actually happening. Some examples of sources that could be used to identify areas that need improvement are: deficiencies in complying with standards, data that indicate unmet outcomes, failure to consistently use "best practice" guidelines, consumer/family dissatisfaction as indicated by surveys, and complaints and **appeals**.

    b. Design and implement the new or modified process: After careful analysis of the problem, the team designs redesigns a process which is expected to improve the process. The change is implemented either system-wide or on a pilot basis.

    c. Measure and Assess: Data are systematically collected and analyzed to assess the impact of a new process. These data are compared to baseline data when available.

    d. Evaluate: If the data indicate that the new or modified process has improved the process, the process is kept in place. If the new or modified process is determined to be ineffective, the team reconvenes to design and implement another process.

e. Inform Senior Management: Senior management should be kept abreast of the team's progress. The results should then be carefully documented and made a part of the organization's record.

H. Evaluation of the Continuity and Effectiveness of the QMP:

1. The BHO must conduct an annual evaluation of the scope and content of the QMP to ensure that it covers all types of services provided in all settings to all categories of enrolled individuals.

2. On an annual basis, the BHO must collect, analyze, and report data to DMHMR regarding the number on new enrollees and the number of individuals who are no longer enrolled. The latter should be grouped in the following categories: those who have selected a BHO, those who are no longer eligible for the services provided by the BHO (and a breakdown of their reasons for ineligibility), those who have chosen not to accept services, and those who have died.

3. On an annual basis, the BHO must collect, analyze, and report data to DMHMR regarding the number of individuals who have had more than one mental health case manager during the previous year with a breakdown of how many consumers have had two mental health case managers, three mental health case managers, and so forth. Also included with these data, should be a compilation of the reasons for changes in mental health case managers and how many individuals changed mental health case managers for each of the identified reasons.

4. At the close of each contract year, the BHO submits to DMHMR a written report on the QMP which addresses: quality improvement studies and other activities completed; trending of data related to desired outcomes; quality improvements made during the previous year; current areas of deficiencies and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. In addition, the BHO submits to DMHMR it revised QMP plan for the next contract year.

Standard II: The Governing Body of the BHO is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the BHO. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to services include:

A. Oversight of the QMP: There is documentation that the Governing Body has approved the overall QMP plan and all subsequent revisions.

B. Oversight Entity: The Governing Body has formally designated an accountable entity or entities within the BHO to provide oversight of the organization's quality assurance/ improvement efforts.

C. Constituting an Advisory Board. The Governing Body has the responsibility for constituting an Advisory Board as required by DMHMR. The primary purposes of the advisory board are to assist the BHO with its internal quality monitoring and to advise the Governing Body regarding issues around the provision of services.

D. QMP Progress Reports: The Governing Body and the Advisory Board receive, at least quarterly, written reports from the QMP which describe actions taken, progress made toward meeting quality assurance/improvement objectives, and improvements made.

E. Annual QMP Review: The Governing Body and the Advisory Board formally review on a periodic basis (but no less frequently than annually) a written report on the QMP which includes, at a minimum, studies undertaken, results, and subsequent actions; aggregate data on utilization; the quality of services provided; progress toward achieving desired outcomes; and an assessment of provider accessibility.

Standard III: The QMP identifies a committee which is responsible for performing quality assurance/ improvement functions within the BHO. The committee has:

A. Regular Meetings: The committee meets on a regular basis with specified frequency to oversee QMP activities. The frequency must be sufficient to demonstrate that the committee is following up on all findings and required actions. The committee must meet at least quarterly.

B. Established Parameters for Operating: The role, structure, and functions of the committee itself are specified in writing.

C. Documentation: There is written documentation of the committee's activities, findings, recommendations, and actions.

D. Accountability: The QMP committee is accountable to the Governing Body and reports to it (or its designee) and the Advisory Board on at least a quarterly basis. Included in the report are the committee's activities, findings, recommendations, and actions.

E. Membership: In addition to staff identified by the BHO, members include provider representatives, a representative from DMHMR's Office of Quality Management Services, a representative from DMHMR's TennCare Division, and a representative from the Department of Health's Bureau of Alcohol and Drug Abuse Services.

Standard IV: There is a designated BHO senior executive who is responsible for implementation and oversight of the QMP. The BHO's Medical Director should also have substantial involvement in the organization's quality assurance/improvement functions.

Standard V: The QMP has sufficient material resources and staff (who have the necessary education, experience, and/or training) to carry out its functions.

Standard VI: There is provider participation in the QMP.

A. Participating providers are kept informed about the written QMP plan.

B. The BHO includes a requirement for complying with the QMP plan requirements in all its provider contracts and employment agreements.

C. Further, all contracts specify that the BHO will have access to all records of its enrollees.

Standard VII: The BHO remains accountable for all QMP functions, even if certain functions are delegated to other entities. If the BHO delegates any quality assurance/improvement activities to providers:

A. There is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the BHO.

B. The BHO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of services being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality assurance/improvement plans and regular specified reports.

Standard VIII: The BHO credentials and recredentials all licensed and/or certified professional staff.

A. The BHO must have written policies and procedures in place which direct the credentialling and recredentialling of licensed and/or certified professional staff. Included in these are:

1. The requirement that the Governing Body or the group to which the Governing Body has formally delegated the credentialling function, has reviewed and approved the credentialling policies and procedures.

2. The designation of a credentialling or other peer review body which makes recommendations regarding credentialling decisions.

3. Identification of those practitioners who fall under its scope of authority and actions. At a minimum this includes: physicians and other licensed and/or certified practitioners who provide mental health and substance abuse treatment (including, but not limited to, clinical and counseling psychologists, psychological examiners, registered nurses, practical nurses, social workers, alcohol and other drug abuse counselors, professional counselors, marital and family counselors, and teachers).

4. The requirements that identified practitioners are credentialled prior to providing services to TennCare Partners Program enrollees and that these practitioners are recredentialled at least every two years thereafter.

5. The requirement that an identified practitioner meet the following criteria in order to be credentialled or recredentialled:

a. is appropriately licensed and/or certified and in good standing (with no sanctions imposed against them by Medicaid, Medicare, TennCare, TDMHMR, the courts, etc.);

b. is appropriately trained and/or has the necessary experience to occupy the identified position within the organization;

c. has demonstrated competencies needed for adequate job performance (for recredentialling, an annual performance evaluation by the supervisor and, possibly, peer reviews will be used as well as other information such as any complaints made about the practitioner, malpractice suits filed, practitioner to practitioner or practitioner performance to benchmark comparison data, etc.); and

d. is free from health problems which could affect his/her practice;

f. in addition, in order to credential or recredential a practitioner, the organization must have adequate facilities, equipment, number and types of support personnel and any other necessary support services to support the professional in the identified position.

6. The BHO is required to offer an appeals process to individual clinicians who are denied credentials or for whom sanctions are imposed.

7. When individuals providing mental health treatment services are not required to be licensed or certified, it is the responsibility of the BHO to assure that, based on the following applicable Tennessee Department of Mental Health and Mental Retardation and Department of Health licensure rules and/or programs standards, that individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

   a. Mental health and substance abuse providers, excluding licensed and/or certified practitioners, who provide the following mental health and substance abuse services in the programs listed below are to be reviewed according to the appropriate state program licensure: a. Programs licensed by the Department of Mental Health and Mental Retardation and the Department of Health which include: Mental Health Day Program (including day treatment and partial hospitalization), Outpatient Mental Health Services (including rehabilitation/ symptom management, crisis services, and regional intervention program), Mental Health Hospital Facilities, Mental Health Residential Treatment Facilities, Mental Health Crisis Stabilization Units, Psychosocial Rehabilitation, Diagnostic and Evaluation Centers, Wilderness Programs (day treatment component), Mental Health Case Management, Substance Abuse Residential, Substance Abuse Outpatient, and all general surgical hospitals operating a unit or program to provide mental health and/or substance abuse services.

   b. Mental health providers, excluding licensed and or certified practitioners, who provide the following mental health services are to be reviewed according to DMHMR Program Standards: Crisis Respite, Housing Developer, Supported Employment, Therapeutic Foster Care, Planned Respite, Emergency Respite, and Infant Stimulation.

   c. Substance abuse providers who provide the following services are to be reviewed according to the appropriate state program licensure: Medical Detoxification, Social Detoxification, Residential Rehabilitation, Adolescent and Residential Rehabilitation, Partial Hospitalization, Halfway House, Youth Day Treatment, Women's Intensive Outpatient, Outpatient, Pregnant Substance Abusers Residential Treatment, Pregnant Substance Abusers Intensive Outpatient, AIDS Outreach, Family Intervention and Referral Services, Methadone Maintenance, Life Development Center (Wilderness Program), and Dual Diagnosis Programs.

B. Practitioners are credentialled initially (prior to delivering services) and are recredentialled at least every two years.

C. The recredentialling process also includes a review of data regarding member complaints, results of quality reviews, utilization management, consumer satisfaction surveys, and reverification, where required, of current licensure.

D. If the BHO delegates credentialling (and recredentialling) activities to provider organizations, there is a written description of the delegated activities and the delegate's accountability for these activities. There is also evidence of that the delegate has accomplished the credentialling activities. The BHO must monitor the effectiveness of the delegate's credentialling and recredentialling process.

E. The BHO retains the right to approve providers and sites and to terminate or suspend individual providers. The BHO has policies and procedures for the suspension, reduction, or termination of practitioner privileges.

F. There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner to the appropriate authorities.

G. There is a provider appellate process for instances where the BHO chooses to reduce, suspend, or terminate a practitioner's privileges with the organization.

H. In accordance with DMHMR requirements, the BHO has a mechanism for notifying DMHMR at the time of network provider additions and deletions

I. Every six months, the BHO reassesses its provider network to assure that all providers are licensed and certified as required by state law and to assure that the composition of the provider network is such that the BHO is in compliance with its access and availability standards relating to geographic coverage of service sites, response time to contact an active service client in an urgent situation, and maximum time for an admission to a service. (NOTE: The BHO's standards must meet or exceed those set forth by DMHMR.) The BHO will report reassessment findings to DMHMR at the mid-point of each contract year and at the end of each contract year.

J. The BHO shall provide input to TDMHMR on an as-needed basis on the rater validity of individuals who administer Target Population Group (TPG) and Clinically Related Group (CRG) assessments.

Standard IX: The BHO must ensure the provision of appropriate, specialized training of practitioners.

A. In order to improve upon the skills of practitioners delivering community mental health and substance abuse services, the BHO provides or requires provider organizations to provide appropriate specialized training which is designed for each service setting.

1. There is a written plan which directs staff training and requires that training be made available, as appropriate, in the following areas:

   a. crisis intervention and resolution, including safety procedures;

   b. medications, medication management, and medication facilitation;

   c. entitlements and procurement of entitlements;

   d. families as a system, including strengths, stressors, dynamics, intervention techniques, and family/professional collaboration;

   e. assessing and using natural support systems;

f. legal issues and mandates regarding mental illness and substance abuse (e.g., forensics, mandatory outpatient treatment, mental health codes, custody, educational rights);

g. community support systems, community-based services, community resources and linkages with these resources;

h. cultural diversity;

i. etiology, treatment, and diagnostic categories of mental illness and substance abuse;

j. etiology and treatment of alcohol and drug abuse, physical and sexual abuse, suicidal ideation, developmental disabilities, and mental retardation;

k. mental health case management principles, practices, and philosophy;

l. mental health case management assessment and mental health case management intervention techniques;

m. service planning and monitoring;

n. CRG assessment and/or TPG assessment;

o. screening for inpatient hospitalization;

p. general health care practices and medical conditions which may be associated with mental illness and substance abuse;

q. age appropriate developmental principles for the consumer populations;

r. CPR and First Aid;

s. consumer rights and consumer advocacy;

t. stress management skills for mental health case managers and other mental health service providers;

u. data management and record keeping;

v. organization policies and procedures;

w. rules, regulations, standards, policies and procedures governing the provision of TennCare-funded mental health services; and

x. diagnosis and treatment of individuals with dual diagnoses.

B. Documentation of training and results of pre-tests and post-tests are maintained by the organizations with whom the individuals trained are employed;

C. Application of knowledge gained through the training is tied to the assessment of staff competency.

Standard X: The BHO demonstrates a commitment to treating consumers in a manner that acknowledges their rights and responsibilities.

A. The BHO has a written policy that recognizes the following rights of consumers:

1. to be treated with respect, dignity, and compassion regardless of state of mind or condition;

2. to be provided treatment without regard to age, race, sex, religion, ethnic background, handicap, or ability to pay;

3. to privacy and confidentiality related to all aspects of care including, but not limited to, the unwarranted disclosure of medical records, whole or in part;

4. to be protected from neglect; to be protected from physical, emotional, or verbal abuse, and from all manner of exploitation;

5. to be informed of any proposed and/or alternative treatment methods; to be informed about the risks, benefits, and side effects of his/her medication or proposed medication;

6. to participate in the development of his/her individual service plan; to participate in all decision-making regarding his/her mental health and substance abuse care; to be involved in his/her discharge or aftercare planning;

7. to be provided quality treatment by competent staff members; to be afforded continuity of care from one service provider to another;

8. to refuse to participate partially or fully in treatment or therapeutic activities (unless participation is so ordered by the court);

9. to be provided treatment in the least restrictive setting feasible;

10. to refuse the use of any audio and/or visual techniques to record or observe the individual's activities during treatment unless written and signed consent is given;

11. to participate in cultural, educational, religious, community service, vocational, and/ or recreational activities;

12. to be provided with information about the BHO, its services, its providers, to be provided with the basic rights and responsibilities of BHO members in a way which is easily understood;

13. to be able to choose providers within the limits of the network; to be able to refuse care from specific providers;

14. to voice **grievances** about the BHO or services provided without fear of restraint, interference, coercion, discrimination, or reprisal;

15. to formulate advance directives; and

16. to have access to his/her records.

B. The BHO has a written policy that addresses consumers' responsibility for cooperating with those providing mental health and substance abuse services. The written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff providing services to the consumer; and

2. following instructions and guidelines given by those providing mental health and substance abuse services.

C. Upon enrollment with the BHO, consumers are provided with a written statement that includes information on the following:

1. rights and responsibilities of consumers;

2. benefits and services included and excluded as a condition of enrollment/ membership, and how to obtain them, including a description of:

   a. any special benefit provision (e.g., co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and

   b. the procedures for obtaining out-of-area coverage;

3. provisions for after-hours and emergency coverage;

4. the BHO's policy on referrals/coordination with physical health care providers;

5. charges to enrollees, if applicable, including:

   a. policy on payment of charges; and

   b. co-payment and fees for which the enrollee is responsible;

6. procedures for formally appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

7. procedures for changing providers;

8. procedures for disenrollment; and

9. procedures for voicing complaints and/or **appeal**s and for recommending changes in policies and services.

D. The BHO has a system, linked to the QMP, for resolving consumers' complaints and for formal **appeals.** This system includes:

1. written procedures for registering and responding to complaints and **appeals** in a timely manner (the BHO should establish and monitor standards for timeliness);

2. documentation of the substance of complaints or **appeals** and actions taken;

3. written procedures to ensure a resolution of the complaint or **appeal**;

4. quarterly aggregation and analysis of complaint and **appeal** data and use of the data for quality improvement; submission of findings to DMHMR on quarterly basis;

5. an appeals process for **appeals**; and

6. a mechanism for reporting all unresolved complaints and concerns to DMHMR on a monthly basis.

E. Opportunity is provided for consumers and their family members to offer suggestions for changes in BHO policies and procedures.

F. The BHO takes steps to promote accessibility of services offered to enrolled consumers. These steps include:

1. identification of the points of access to the comprehensive array of mental health services are identified for consumers; and

2. at a minimum, consumers are given information about:

a. how to obtain services during regular hours of operations;

b. how to obtain emergency and after-hours care; and

c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for the delivery of mental health services.

G. The BHO will provide written information to enrollees which is:

1. Written in prose that is easily readable and easily understood;

2. Available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10% of the enrollees; and

3. Explained to individuals who are unable to read or understand easily or explained to a consumer's parent, guardian, or other appropriate person responsible for protecting the rights of the consumer.

H. The BHO acts to ensure that the confidentiality of specified consumer information and records is protected.

1. The BHO has established in writing and enforces policies and procedures on confidentiality, including confidentiality of consumer records.

2. The BHO ensures that all providers have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the provider's organization.

3. The BHO will hold confidential all information obtained by its personnel about enrollees related to their examination, care, and treatment and will not divulge it without the enrollee's authorization unless:

a. it is required by law,

b. it is necessary to coordinate the consumer's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

c. it is necessary in compelling circumstances to protect the health or safety of an individual.

4. The written consent of the consumer or his/her legal representative is considered valid only if the following conditions are met:

a. The consumer or representative is informed, in a manner understood by the consumer or his/her representative, of the specific type of information that has been requested;

b. The consumer or representative is informed that the provision of services is not contingent on his/her decision concerning the release of information to other internal or external services; and

c. The consent of the consumer or representative is acquired in accordance with applicable laws and regulations.

5. Any release of information in response to a court order is reported to the consumer in a timely manner.

6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity.

I. The BHO has written policies regarding the appropriate treatment of minors.

J. The organization conducts periodic surveys of consumer and family member satisfaction with its services.

1. The surveys include content on perceived problems with the quality, availability, and accessibility of care. Consumers and family members are also surveyed regarding their perceptions of how they have been treated by service providers.

2. The surveys assess at least a sample of:

a. each of the clinically related groups, target populations, and non-target populations;

b. family members of each of individuals in each of the clinically related group, target population, and non-target populations;

c. consumers who have filed complaints about services or providers or who have requested a change of provider; and

d. members of mental health and substance abuse consumer advocacy groups.

3. As a result of the surveys, the BHO:

a. identifies and investigates sources of dissatisfaction;

b. outlines action steps to follow-up on the findings; and

c. informs providers of assessment results.

4. Annually, survey findings and information regarding follow-up actions are made available to DMHMR.

5. The BHO reevaluates the effects of the activities 1.-4. above.

Standard XI: The BHO has established standards for access (e.g., to routine, emergency care; for information; for referrals; etc.) and for availability which meet or exceed standards set by TDMHMR. Performance on the dimensions of access and availability are assessed against the standards set in the Performance Measurement document.

Standard XII: The BHO maintains standards for facilities in which consumers are served.

A. This includes compliance with existing state and local laws regarding safety and accessibility (including the requirement that hospitals providing inpatient services are JCAHO accredited);

B. A requirement for adherence to these standards is contained in all of the BHO's provider contracts.

Standard XIII: The BHO is in compliance with all standards for consumer records.

A. The BHO will include provisions in provider contracts for appropriate access to records of its enrollees for purposes of quality reviews conducted by the BHO, by DMHMR, by TennCare, or agents thereof.

B. Records are available to practitioners at each encounter.

C. Records may be on paper or electronic media. The BHO takes steps to promote maintenance of consumer records in a legible, current, detailed, organized, and comprehensive manner which permits effective service provision and quality reviews as follows:

1. The BHO sets standards for consumer records. These standards will, at a minimum, include requirements that:

A. Information related to the provision of appropriate services to a consumer is to be included in his/her record. This information includes:

1. For individuals in the target populations, a description of the consumer's physical and mental health status at the time of enrollment. This comprehensive assessment covers:

* a psychiatric assessment which includes: description of the presenting problem, psychiatric history and history of consumer's response to crisis situations, psychiatric symptoms, five axis diagnosis of mental illness using the most current edition of DSM, mental status exam, and history of alcohol and drug abuse;

* a medical assessment which includes: screening for medical problems, medical history, and present medications, and medication history;

* Target Population Group (TPG) and Clinically Related Group (CRG) assessments are performed by persons designated by the BHO who have been trained by TDMHMR and who have passed the TDMHMR competency tests; these persons must use the CRG and TPG assessment form(s) prescribed by and in accordance with the policies of TDMHMR; these assessments are subject to the review and approval of TDMHMR. [Note: CRG and TPG assessments must have been performed for all enrollees within six months prior to the Partners Program implementation date.]

* a community functioning assessment or status to assess the consumer's functioning in the following domains: living arrangements, daily activities (vocational/educational), social support, financial, leisure/ recreational, physical health and emotional/behavioral health;

* an assessment of: consumer strengths, current life status, personal goals, and needs; and

* a reassessment of these areas which is performed annually or sooner if warranted by a significant change in psychiatric symptoms, medical conditions, or community functioning level.

2. The services to be provided/the individualized treatment plan which is based on the psychiatric, medical, and community functioning assessments listed above and which includes (this is applicable for members of the target population and for all others who are in receipt of mental health services for thirty days or longer):

   * documentation of medical necessity;

   * provision of either mental health case management or continuous treatment team services;

   * goals;

   * objectives and target dates;

   * action steps and responsible parties for each objective;

   * the specialized mental health and substance abuse services to be delivered (provider, location, frequency of contact, planned start date, and period of authorized services);

   * progress notes related to goals and objectives;

   * plan for prevention and/or resolution of crisis; and

   * documentation that the service plan is reviewed and revised if needed every three months by individuals responsible for its development.

3. Documentation that the rights of the consumer have been explained and are protected.

4. Documentation that the consumer and, as appropriate, his/her family members participated in the development and subsequent review of the treatment/service plan.

5. The following identifying data recorded on a standardized form:

    a. Full legal name;

    b. Home address;

    c. Home telephone number;

    d. Date of birth;

    e. Sex;

    f. Race or ethnic origin;

    g. Conservator or guardian;

    h. Education;

    i. Marital status;

    j. Type and place of employment;

    k. Date of initial contact or enrollment with BHO;

    l. Legal status, including relevant legal documents;

    m. Other identifying data as indicated;

    n. Date the information was gathered; and

    o. Signature of staff member gathering the information.

6. Occurrence reports and information on any unusual occurrences such as the following: (NOTE: On a monthly basis, the BHO must submit to DMHMR all occurrence reports and their dispositions.)

    a. Treatment complications (including medication errors and adverse medication reactions);

    b. Accidents or injuries to the consumer;

    c. Morbidity;

    d. Death of the consumer;

    e. Allegations of physical abuse, sexual abuse, and/or verbal abuse;

f. Use of physical, mechanical, and/or chemical restraints; and

g. Incidents of absence without leave.

7. Documentation, as necessary, of consumer/legal representative/family member consent for admission, treatment, evaluation, continuing care, release of records for information, or research.

8. Documentation of physical and mental diagnoses that have been made using a recognized diagnostic system.

9. Reports of laboratory, radiological, or other diagnostic procedures and reports of medical/surgical services when performed;

10. Hospital discharge summaries for all hospital admissions which occur while the consumer is enrolled with the BHO and for all previous admissions related to the consumer's mental illness or substance abuse.

11. Correspondence concerning the consumer's treatment and signed and dated notations of telephone calls concerning the consumer's treatment;

12. Documentation when information about the consumer is released to an individual or organization;

13. A copy of the individual's advance directive or notation that the consumer has not executed one; and

14. A discharge summary or summation summary (if the consumer dies) within fifteen days following disenrollment or death.

B. All entries in records are signed by the author and dated.

C. Records are kept for a minimum of five years after disenrollment or death of an individual.

D. There is a record review process to assess the content of the consumer records for legibility, organization, completion, and conformance to its standards listed above.

Standard XIV: The BHO implements a structured utilization review process.

A. The BHO has a written utilization management program description which includes, at a minimum, plans for compliance with utilization management criteria set by DMHMR, procedures to evaluate medical necessity (including evaluation criteria and sources of information), and the process for reviewing and approving the provision of medical services.

B. The program has mechanisms to detect under utilization as well as over utilization.

C. For preauthorization and concurrent review programs:

1. Preauthorization and concurrent review decisions are supervised by qualified mental health or substance abuse professionals.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating mental health or substance abuse professional as appropriate.

3. The reasons for decisions are clearly documented and available to the consumer.

4. There are well-publicized and readily available appeals mechanisms for both providers and consumers.

5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

6. There are mechanisms to evaluate the effects of the program using data on consumer and family satisfaction, provider satisfaction, and other appropriate measures.

7. If the BHO delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

D. The program has mechanisms and plans for provider profiling using provider utilization data.

Standard XV: The BHO has put a basic system in place which promotes continuity of care through a structured, well-established mental health case management system. As directed by the Partners Program contract, mental health case management services are offered by the BHO to all adults with serious and persistent mental illness (clinically related groups 1, 2, and 3) and children with serious emotional disturbances who fall within target population group 2.

Standard XVI: There is written documentation of QMP implementation.

A. The BHO will document that, in accordance with its written QMP plan, it is monitoring and evaluating the quality of care across all services and all treatment modalities and to all population groups.

B. The BHO must maintain and make available to DMHMR and to TennCare all studies, reports, protocols, standards, worksheets, minutes, or such documentation as may be appropriate, concerning its quality assurance/improvement activities and corrective actions.

Standard XVII: The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of the quality assurance/improvement activities are documented and reported to appropriate individuals within the organization and through the established quality assurance/ improvement channels.

A. Quality assurance/improvement information is used in recredentialling, reconstructing, and/or annual performance evaluations.

B. Quality assurance/improvement activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and **appeals**.

C. There is a linkage between quality assurance/improvement and other management functions of the BHO such as network changes, service redesigns, benefits changes, and medical management system

ATTACHMENT D

Data Reporting Requirements

REPORTING DATA ELEMENTS

REQUIRED DATA ELEMENTS FOR REPORTING ENROLLEE INFORMATION

This report shall include, at a minimum, the following data elements;

1. Enrollee's name;
2. Enrollee's social security number;
3. Enrollee's date of birth;
4. Enrollee's sex;
5. Enrollee's previous address;
6. Enrollee's new address; or to the extent possible, a statement or indicator that the enrollee's new address is unknown due to mail being returned for insufficient address (e.g., undeliverable, no forwarding address, etc.) if the enrollee's new address is unknown;
7. Date enrollee moved;
8. A statement or indicator whether the enrollee's new address is within the same community service area as the former address or is in a different community service area;
9. Identity of the new MCO plan, if known, if the enrollee has moved outside the former community service area and desires to change MCO plans;
10. The identity of the MCO providing notice; and
11. Other pertinent information which is known by the Contractor which may have an affect on an enrollee's eligibility or cost sharing status.

AND

REQUIRED ELEMENTS FOR ENROLLEE VERIFICATION REPORTING

In response to receipt of a file from TennCare that identifies individuals whom TennCare has not been successful at contacting to verify eligibility, the Contractor will provide a response file that will include, at a minimum, the following data elements:

1. Enrollee's social security number;
2. Enrollee's date of birth;
3. Enrollee's sex;
4. Enrollee's name; and
5. Enrollee's address

Required Data Elements

Required Data Elements for Provider Information Base

At a minimum, the following data elements shall be collected for each provider in the BHO's network.

Provider Last Name
Provider First Name
Provider Middle Initial
Provider Address
Provider City
Provider State
Provider Zip
Provider SSN
Provider License Number
Provider TennCare Number or BHO Number
Provider UPIN Number
Provider Type
Provider Phone Number
Provider Participation Begin Date
Provider Participation End Date

Attachment D.2

Participant Intake and Service Discontinuation Reporting

Required Data Elements

Required Data Elements for Participant Intake for Mental Health or Substance Abuse Services

At a minimum, the following data elements shall be collected for Participants accessing Mental Health or Substance Abuse Services:

Common Data Elements

Admission or Action
Behavioral Health Organization's (BHO) ID Number

Participant's Date of Birth
Participant's Name
Participant's Social Security Number

Required Data Elements for Discontinuation of Services

At a minimum, the following data elements shall be collected when term of care is discontinued.

Attachment D.3

Clinically Related Group Assessment Reporting

Required Data Elements

Required Data Elements For Clinically Related Group Assessment Of Participants Age 18 or Older

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Participant's Last Name
Participant's First Name

Participant's Birth Date
Participant's Social Security Number (SSN)
Measure of Participant's Level of Functioning in Activities of Daily Living
Measure of Participant's Level of Functioning in Interpersonal Functioning
Measure of Participant's Level of Functioning in Concentration, Task Performance, and Pace
Measure of Participant's Level of Functioning in Adaptation to Change
Measure of Participant's Severity of Impairment
Measure of Participant's Duration of Mental Illness
Indicator of Participant's Former Impairment
Measure of Participant's Need for Services to Prevent Relapse
Determination of Participant's Clinically Related Group
Date of Clinically Related Group Assessment
Measure of Rater's Adequacy of Information in Order to Complete Assessment
Rater's Social Security (SSN) or Employer ID Number

Attachment D.4

Target Population Group Assessment Reporting

Required Data Elements

Required Data Elements For Target Population Group Assessment Of Participants Under Age 18

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Date of Assessment
Participant's Last Name
Participant's First Name

Participant's Date of Birth

Participant's Social Security Number
Does Participant have DSM IV Diagnosis other than V-code, substance abuse or developmental disorder
Axis V - Current GAF

Functional Impairment-Severe or Not
Serious Emotional Disturbance (SED) Status
At Risk of SED -Environmental
At Risk of SED - Level of family dysfunction
At Risk of SED - Traumatic events
At Risk of SED - Lack of social skills
At Risk of SED - Physical or sexual abuse or neglect

Rater's Social Security or Employer ID Number

Attachment D.5

Encounter Reporting

Required Data Elements

Required Data Elements for Encounter Information Base

At a minimum, the following data elements shall be collected for Encounter Data.

Allowed Amount
Amount Paid
Coinsurance Amount
Date Paid
Deductible Amount
Diagnosis Code
Emergency Indicator
EPSDT Last Screening Date
EPSDT Screening Related Treatment Indicator
Participants Identification Number
HCPC Procedure Code Modifier
Behavioral Health Organization ID
Medical Record Number
Participant Date of Birth
Participant First Name
Participant Middle Initial
Participant Last Name
Place of Service
Pricing Number
Pricing Level
Primary Carrier Payment by Line Number
Primary Carrier Total Amount Paid
Procedure Code (CPT-4 or other code as designated by TDMHDD)
Provider Identifier
Provider Specialty Code
Referring Provider TennCare ID
Rendering Provider TennCare ID
Service from Date
Service thru Date
Total Allowed Amount
Total Amount Paid
Total Coinsurance Amount
Total Deductible Amount
Total Document Charges
Type of Service
Units of Service
Admission Date
Admission Hour
Admitting Diagnosis
Ancillary Noncovered Charge
Ancillary Revenue Code
Ancillary Total Charge
Ancillary Units of Service
Attending Physician
Condition Code
Bill Classification
Billing Frequency
Covered Days
Facility Type
Noncovered Days
Occurrence Code
Occurrence Date

Occurrence Span Code

Occurrence Span From Date
Occurrence Span Through Date
Other Diagnosis
Other Physician Number
Other Procedure code
Other Procedure Date
Source of Admission

Pharmacy Specific

Dispensing Fee
Drug Price
National Drug Code
National Drug Units
Ordering Provider UPIN Number
Prescription Number
Number of Refills
Provider State Licensee Number
Date Per
Provider SSN
Provider License Number
Provider TennCare Number or BHO Number
Provider UPIN Number
Provider Phone Number
Provider's Participation Begin Date
Provider's Participation End Date

Attachment D.6

Participant Outcome Reporting

Required Data Elements

Required Data Elements For Participant Outcome Information Base

At a minimum, the following data elements shall be collected for Participants:.

Work In Progress -

ATTACHMENT E

PERFORMANCE MEASURES AND LIQUIDATED DAMAGES

Within 60 days of the execution of this CONTRACT amendment, the State will provide the CONTRACTOR with a revised Attachment F which will revise and prioritize the reasonable key performance measures and establish reasonable timetables for meeting these measures. The CONTRACTOR will participate in the revision process. The revised Attachment F will be substituted for the existing Attachment F at such time as HCFA approval has been obtained. Until HCFA approval for a revised Attachment F is received, the existing Attachment F will remain in effect.

Chart of Deficiency Types, Definitions, & Liquidated Damage

Deficiency Type	**Definition**	**Number of Measures**	**Liquidated Damages**
I	A performance standard which, if not met, denotes that the BHO's provider network no longer renders statewide coverage.	10	$2,000 will be assessed for each Type I deficiency found at the time of annual review
II	A performance standard which, if not met, is likely to result in physical or psychological harm to a Partner's Program Participant.	5	$1,000 will be assessed for each Type II deficiency found at the time of annual review
III	A performance standard which, if not met, has the potential to result in physical or psychological harm to a Partner's Program Participant.	32	$500 will be assessed for each Type III deficiency found at the time of annual review
IV	A performance standard which, if not met, is likely to cause undue distress to a Partner's Program Participant.	74	$500 will be assessed for each Type IV deficiency found at the time of annual review
V	A performance standard which, if not met, may result in significant losses in the number of providers in the BHO's network.	9	$250 will be assessed for each Type V deficiency found at the time of annual review
VI	A performance standard which, if not met, prevents the State from monitoring the BHO's performance.	9	See Section 5.3.3 of Contract

ATTACHMENT F

TENNCARE SCHEDULES

Attachment F **SCHEDULE A**

TennCare Deductibles and Out-Of-Pocket Expenditures

Percentage of Poverty	**0% - 100%**	**101% - Over**
Less than 200% of Poverty		
Annual Deductible (Individual)	$0	$250
Annual Deductible (Family)	$0	$500
Out-Of-Pocket Expenses (Individual)	$0	$1,000
Out-Of-Pocket Expenses (Family)	$0	$2,000
Family Size	**Monthly Income**	**Monthly Income**
1	**0 - 650**	**651 - Over**
2	**0 - 871**	**872 - Over**
3	**0 - 1,092**	**1,093 - Over**
4	**0 - 1,312**	**1,313 - Over**
5	**0 - 1,532**	**1,533 - Over**
6	**0 - 1,753**	**1,754 - Over**
7	**0 - 1,974**	**1,975 - Over**
8	**0 - 2,194**	**2,195 - Over**
9	**0 - 2,415**	**2,416 - Over**
10*	**0 - 2,635**	**2,636 - Over**
***For each family member over 10, add per month**	**0 - 219**	**220 - Over**

SCHEDULE B

TennCare Premium Sliding Scale
Up To 200% of Poverty Level
Uninsured/Uninsurable

Percentage of Poverty	**0% - 100%**	**101% - 119%**	**120% - 139%**	**140% - 169%**	**170% - 199%**
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	**0 - 650**	**651 - 773**	**774 - 902**	**903 - 1,096**	**1,097 - 1,289**
2	**0 - 871**	**872 - 1035**	**1036 - 1207**	**1,208 - 1,466**	**1,467 - 1,725**
3	**0 - 1,092**	**1,093 - 1,297**	**1,298 - 1,514**	**1,515 - 1,838**	**1,839 - 2,163**
4	**0 - 1,312**	**1,313 - 1,559**	**1,560 - 1,819**	**1,820 - 2,209**	**2,210 - 2,599**
5	**0 - 1,532**	**1,533 - 1,821**	**1,822 - 2,124**	**2,125 - 2,580**	**2,581 - 3,035**
6	**0 - 1,753**	**1,754 - 2,083**	**2,084 - 2,431**	**2,432 - 2,952**	**2,953 - 3,473**
7	**0 - 1,974**	**1,975 - 2,345**	**2,346 - 2,736**	**2,737 - 3,323**	**3,324 - 3,909**
8	**0 - 2,194**	**2,195 - 2,607**	**2,608 - 3,041**	**3,042- 3,693**	**3,694 - 4,345**
9	**0 - 2,415**	**2,416 - 2,869**	**2,870 - 3,348**	**3,349 - 4,065**	**4,066 - 4,783**
10*	**0 - 2,635**	**2,636 - 3,131**	**3,132 - 3,653**	**3,654 - 4,436**	**4,437 - 5,219**
***For each family member over 10, add per month**	**0 - 219**	**220 - 261**	**262 - 304**	**305 - 370**	**371 - 435**
Individual Monthly Premium Amount	**$0**	**$14.25**	**$17.50**	**$23.50**	**$32.75**
Family Monthly Premium	**$0**	**$24.50**	**$32.25**	**$47.50**	**$70.50**

TennCare Premium Sliding Scale
200% Through 399% of Poverty Level
Uninsured/Uninsurable

Percentage of Poverty	**200% - 209%**	**210% - 219%**	**220% - 239%**	**240% - 269%**	**270% - 299%**	**300% - 349%**	**350% - 399%**
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	**1,290 - 1,354**	**1,355 - 1,418**	**1,419 - 1,547**	**1,548 - 1,741**	**1,742 - 1,934**	**1,935 - 2,257**	**2,258 - 2,579**
2	**1,726 - 1,811**	**1,812 - 1,898**	**1,899 - 2,070**	**2,071 - 2,329**	**2,330 - 2,588**	**2,589 - 3,020**	**3,021 - 3,451**
3	**2,164 - 2,271**	**2,272 - 2,379**	**2,380 - 2,596**	**2,597 - 2,920**	**2,921 - 3,245**	**3,246 - 3,786**	**3,787 - 4,327**
4	**2,600 - 2,729**	**2,730 - 2,859**	**2,860 - 3,119**	**3,120 - 3,509**	**3,510 - 3,899**	**3,900 - 4,549**	**4,550 - 5,199**
5	**3,036 - 3,187**	**3,188 - 3,339**	**3,340 - 3,642**	**3,643 - 4,098**	**4,099 - 4,553**	**4,554 - 5,312**	**5,313 - 6,071**
6	**3,474 - 3,647**	**3,648 - 3,820**	**3,821 - 4,168**	**4,169 - 4,689**	**4,690 - 5,210**	**5,211 - 6,079**	**6,080 - 6,947**
7	**3,910 - 4,105**	**4,106 - 4,300**	**4,301 - 4,691**	**4,692 - 5,278**	**5,279 - 5,864**	**5,865 - 6,842**	**6,843 - 7,819**
8	**4,346 - 4,562**	**4,563 - 4,780**	**4,781 - 5,214**	**5,215 - 5,866**	**5,867 - 6,518**	**6,519 - 7,605**	**7,606 - 8,691**
9	**4,784 - 5,022**	**5,023 - 5,261**	**5,262 - 5,740**	**5,741 - 6,457**	**6,458 - 7,175**	**7,176 - 8,371**	**8,372 - 9,567**
10*	**5,220 - 5,480**	**5,481 - 5,741**	**5,742 - 6,263**	**6,264 - 7,046**	**7,047 - 7,829**	**7,830 - 9,134**	**9,135 - 10,439**
***For each family member over 10, add per month**	**436 - 457**	**458 - 479**	**480 - 522**	**523 - 588**	**589 - 653**	**654 - 762**	**763 - 871**
Individual Monthly Premium	**$73.50**	**$80.50**	**$87.75**	**$98.75**	**$109.75**	**$128.00**	**$146.50**
Family Monthly Premium	**$183.50**	**$200.75**	**$219.25**	**$246.75**	**$274.00**	**$320.00**	**$365.75**

SCHEDULE C

TennCare Premium Sliding Scale
400% and Over of Poverty Level
Uninsured

Percentage of Poverty	**400% - 749%**	**750% - Over**
Family Size	**Monthly Income**	**Monthly Income**
1	**2,580 - 4,837**	**4,838 - Over**
2	**3,452 - 6,472**	**6,473 - Over**
3	**4,328 - 8,114**	**8,115 - Over**
4	**5,200 - 9,749**	**9,750 - Over**
5	**6,072 - 11,384**	**11,385 - Over**
6	**6,948 - 13,027**	**13,028 - Over**
7	**7,820 - 14,662**	**14,663 - Over**
8	**8,692 - 16,297**	**16,298 - Over**
9	**9,568 - 17,939**	**17,940 - Over**
10*	**10,440 - 19,574**	**19,575 - Over**
***For each family member over 10, add per month**	**872 - 1,634**	**1,635 - Over**
Individual Monthly Premium	**$184.75**	**$190.25**
Family Monthly Premium	**$461.50**	**$475.50**

TennCare Premium Sliding Scale
400% and Over of Poverty Level
Uninsured

Percentage of Poverty	**400% - 749%**	**750% - Over**
Family Size	**Monthly Income**	**Monthly Income**
1	**2,580 - 4,837**	**4,838 - Over**
2	**3,452 - 6,472**	**6,473 - Over**
3	**4,328 - 8,114**	**8,115 - Over**
4	**5,200 - 9,749**	**9,750 - Over**
5	**6,072 - 11,384**	**11,385 - Over**
6	**6,948 - 13,027**	**13,028 - Over**
7	**7,820 - 14,662**	**14,663 - Over**
8	**8,692 - 16,297**	**16,298 - Over**
9	**9,568 - 17,939**	**17,940 - Over**
10*	**10,440 - 19,574**	**19,575 - Over**
***For each family member over 10, add per month**	**872 - 1,634**	**1,635 - Over**
Individual Monthly Premium	**$225.00**	**$231.50**
Family Monthly Premium	**$562.00**	**$578.75**

SCHEDULE D

TennCare Co-Pay Sliding Scale

Percentage of Poverty	**0% - 100%**	**101% - 119%**	**120% - 139%**	**140% - 169%**	**170% - 199%**	**200% - Over**
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	**0 - 650**	**651 - 773**	**774 - 902**	**903 - 1,096**	**1,097 - 1,289**	**1,290 - Over**
2	**0 - 871**	**872 - 1,035**	**1,036 - 1,207**	**1,208 - 1,466**	**1,467 - 1,725**	**1,726 - Over**
3	**0 - 1,092**	**1,093 - 1,297**	**1,298 - 1,514**	**1,515 - 1,838**	**1,839 - 2,163**	**2,164 - Over**
4	**0 - 1,312**	**1,313 - 1,559**	**1,560 - 1,819**	**1,820 - 2,209**	**2,210 - 2,599**	**2,600 - Over**
5	**0 - 1,532**	**1,533 - 1,821**	**1,822 - 2,124**	**2,125 - 2,580**	**2,581 - 3,035**	**3,036 - Over**
6	**0 - 1,753**	**1,754 - 2,083**	**2,084 - 2,431**	**2,432 - 2,952**	**2,953 - 3,473**	**3,474 - Over**
7	**0 - 1,974**	**1,975 - 2,345**	**2,346 - 2,736**	**2,737 - 3,323**	**3,324 - 3,909**	**3,910 - Over**
8	**0 - 2,194**	**2,195 - 2,607**	**2,608 - 3,041**	**3,042 - 3,693**	**3,694 - 4,345**	**4,346 - Over**
9	**0 - 2,415**	**2,416 - 2,869**	**2,870 - 3,348**	**3,349 - 4,065**	**4,066 - 4,783**	**4,784 - Over**
10*	**0 - 2,635**	**2,636 - 3,131**	**3,132 - 3,653**	**3,654 - 4,436**	**4,437 - 5,219**	**5,220 - Over**
***For each family member over 10 add per month**	**0 - 219**	**220 - 261**	**262 - 304**	**305 - 370**	**371 - 435**	**436 - Over**
Percentageof Payments	**0%**	**2%**	**4%**	**6%**	**8%**	**10%**

Mental Health (Episodic Conditions) Copayments*

Service	**Co-Pay**
Outpatient Mental Health Services (including physician services)	45 visits per year (25% of the MCOs negotiated rate for the first 15 50% of the MCOs negotiated rate for the next 15 75% of the MCOs negotiated rate for the next 15)

* These co-payments do not apply for people in the Priority Population who otherwise have co-payment obligations. For people in the **Basic Population** who otherwise have co-payment obligations, these payments are <u>in lieu</u> of those co-payments and are not <u>in addition to</u> those co-payments.

Special Fees

Service	**Fee**
Emergency Room Services (non-emergency room situations)	$25 Per Visit For Non-Medicaid Eligible Enrollees

ATTACHMENT G

DELIVERABLES

Attachment G

Deliverable Requirements

The contractor and TDMHDD, TennCare and TDCI are responsible for complying with all the deliverable requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of deliverables, as well as the timely submission of each deliverable. Both parties will agree to the appropriate deliverable instructions, submission timetables, and technical assistance as required.

I. Items requiring prior approval by TDMHDD, TennCare and/or TDCI

A. The Contractor's provider network and any deletions or additions; regular monthly updates of the provider network;	TDMHDD has fifteen (15) calendar days to respond.
B. Marketing plans and related materials, such as Member Handbooks (Explanations of Benefits); within 15 days after execution of this CONTRACT; any time thereafter prior to distribution.	TDMHDD has fifteen (15) calendar days to respond.
C. Any additional benefits to be provided; prior to implementation	TDMHDD has fifteen (15) calendar days to respond.
D. Provider relations plan; with signed CONTRACT.	TDMHDD will respond prior to issuing CONTRACT.
E. Participant involvement plan; with signed CONTRACT.	TDMHDD will respond prior to issuing CONTRACT.
F. Any subcontracts which may be contract(s) for any services other than the services and benefits provided to Participants; prior to execution of such contract(s).	TDMHDD has fifteen (15) calendar days to respond.
G. Appeal and complaint procedures; with signed CONTRACT.	TDMHDD and TennCare will respond prior to executing CONTRACT.
H. Reporting procedures; as specified in the CONTRACT.	TDMHDD, TennCare and/or TDCI will respond prior to issuing CONTRACT.
I. Indemnity language found in provider contracts if different from the standard indemnity language found in this CONTRACT; prior to issuing such contracts.	TDMHDD and TennCare have fifteen (15) calendar days to respond.
J. Quality Monitoring/Quality Improvement procedures; within thirty (30) days after execution of this CONTRACT; annually thereafter.	TDMHDD has fifteen (15) calendar days to respond.
K. Certificates of insurance and bonding with signed CONTRACT.	TDCI will respond prior to issuance of CONTRACT.
L Arbitration procedures; with signed CONTRACT.	TDMHDD will respond prior to issuing CONTRACT.
M. Written plan for centralized credentialing and recredentialing of providers and potential providers; With signed CONTRACT	TDMHDD will respond prior to issuing CONTRACT.

II. Deliverables which are the responsibility of the Contractor

A. Annual report – submitted on a form prescribed by the National Association of Insurance Commissioners	Due on or before March 1 of each calendar year to TDCI, TennCare Division.
B. Quarterly financial report – submitted on a form prescribed by the National Association of Insurance Commissioners.	Due on or before May 1 of each year to TDCI, TennCare Division
C. Audit of Business Transactions/Audited Financial Statements (including income statement)	Due on or before May 1 of each year to TDCI, TennCare Division
D. Written plan of changes resulting from an audit	Within fifteen (15) working days
E. Ownership and Financial Disclosure	With signed CONTRACT
F. Significant business transaction	Upon occurrence
G. Reports of appeals and resolution	Monthly, to the Office of Quality Management, TDMHDD
H. Appeals regarding Emergency Medical Service claims	Monthly, to the Office of Quality Management, TDMHDD
I. All required QI/QM reports	To the Office of Quality Management, TDMHDD
J. Return of funds (overpayments)	Thirty (30) calendar days following notification
K. Performance Measures Reports as specified in Attachment E	Monthly, Quarterly, Semi-Annually or Annually, as in Attachment E, to the Office of Evaluation and Statistical Analysis, TDMHDD
L. Report of number of Participants who have refused Mental Health Case Management services	Quarterly, to TDMHDD
M. Reports regarding the activities of the BHO Advisory Committee	Semi-annually, to TDMHDD

III. Deliverables which are the responsibility of TDMHDD

Reports concluding findings, recommendations and requirements from monitoring activities conducted by TDMHDD and/or HCFA

IV. Deliverables which are the responsibility of TennCare

A. Weekly listing of persons enrolled in the Contractor's plan

B. Reports listing persons disenrolled from the Contractor's plan

ATTACHMENT H

Profit/Loss Risk Banding

BHO Manual

State of Tennessee
Bureau of TennCare

Revised 3/12/01

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ATTACHMENT H

Section One
Description of Risk Banding

The purpose of this program is to allow a Behavioral Health Organization (BHO) to limit their net profit or loss based upon their participation in the TennCare program.

TennCare will pay a capitation rate using a capitation rate schedule. In addition, the Bureau will allow the BHOs the option of participating in a profit/loss risk banding program. The profit/loss risk banding is intended to share risk between the State and the BHOs at predetermined coinsurance levels that vary by the level of profit and loss actually incurred and reported to the Tennessee Department of Commerce and Insurance (TDCI). For those BHOs who choose to not participate, they are at risk for 100% of the profit and loss surrounding the capitation payments. For BHOs choosing to participate, the option they choose will be effective for January 1, 2001 through June 30, 2001. The BHO may change the risk band option by notifying the State within seven (7) days of receipt of the recalibrated rates after the open enrollment period in 2001. The subsequent risk band will be effective from July 1, 2001 through December 31, 2001. The BHO may opt to change risk band options a final time by notifying the State in writing no later than December 1, 2001, and the subsequent risk band option will be effective January 1, 2002 through June 30, 2002.

All TennCare eligible populations are covered by the risk banding, as well as all medically necessary TennCare covered services as described in the contractor risk agreement (CRA) and any subsequent amendments.

Section Two
Risk Banding Options

Each BHO has the option of electing to participate in the State-sponsored Profit/Loss Risk Banding program. Each BHO must choose one of the following three options:

Option 1: The CONTRACTOR is responsible for all of the first 2% gain or loss and shares in any amount beyond the first 2% gain or loss
Option 2: The State and the CONTRACTOR share immediately in all gains and losses
Option 3: The CONTRACTOR assumes all risk under this agreement

The risk sharing varies dependent upon the percentage above and below total TennCare revenue. All examples assume the TennCare revenue to be net of the premium tax. For risk 10% above or below TennCare revenue in Options 1 and 2, see the chart below. All risk bands are incremental. For example, a contractor with net income of 3% that chose option 1 would return 70% of the net income in excess of 2%. The final calculation yields 70% x 1% (3%-2%), since there is no sharing on the first 2% of the net income/loss differential. The table below illustrates the risk banding options by year.

For Calendar Year Ended December 31, 2001

Risk Banding Options	***Net Income Between 0% and 2% TennCare's Share***	***Net Loss Between 0% and 2% TennCare's Share***	***Net Income Between 2% and 10% TennCare's Share***	***Net Loss between 2% and 10%, TennCare's Share***	***Net Income Greater than 10% TennCare's Share***	***Net Loss Greater than 10% TennCare's Share***
Option 1	**No Sharing**	**No Sharing**	**70%**	**50%**	**90%**	**90%**
Option 2	**70%**	**50%**	**70%**	**50%**	**90%**	**90%**

For Contract Year Ended June 30, 2002

Risk Banding Options	***Net Income Between 0% and 2% TennCare's Share***	***Net Loss Between 0% and 2% TennCare's Share***	***Net Income Between 2% and 10% TennCare's Share***	***Net Loss between 2% and 10%, TennCare's Share***	***Net Income Greater than 10% TennCare's Share***	***Net Loss Greater than 10% TennCare's Share***
Option 1	**No Sharing**	**No Sharing**	**70%**	**50%**	**90%**	**90%**
Option 2	**70%**	**50%**	**70%**	**50%**	**90%**	**90%**

Section Three
Adjudication/Reconciliation Methodology

Adjudication

BHO's must submit their preliminary payout estimates for their net income or loss within 90 days of the end of the settlement period. Any payouts made by the Bureau or the BHO must include the final impact on BHO net income or loss as a result of the 85% medical loss reconciliation process. The State must make a preliminary payout within sixty days of the receipt of the BHOs preliminary estimate and only after the final 85% medical loss ratio reconciliation has been completed. The final payout will be based on final claims run-out for the period ending either December 31 or June 30. The final claims run-out must be certified by an actuary that a claim run-out of 95% for the settlement period has been achieved and the medical loss ratio reconciliation (required to be completed within 90 days of the end of the settlement period) has been accomplished.

Any error of estimation as a result of the final adjudication of the profit/loss risk banding or the medical loss ratio reconciliation will be included in the next settlement period's calculations.

BHOs must agree to reasonable reimbursement standards to be determined in conjunction with the actuarially sound rate setting assumptions. The CONTRACTOR shall not pay more for services rendered by any provider or subContractor that is related to the CONTRACTOR than the CONTRACTOR pays to unrelated providers and subContractors for similar services. Any payments made by the CONTRACTOR nditures prior to the State sharing in any losses. Likewise, this excess payment will be excluded in the calculation of the medical loss ratio requirement. All reimbursement paid to providers is subject to audit by the State.

On an annual basis, the BHOs are required to pend 85% of their total capitation payments received from TennCare upon payments to providers for covered medical services. This 85% standard, known as the 85% Medical Loss Ratio (MLR) standard, will be reconciled for each settlement period for BHOs participating in the optional profit/loss risk-banding program. The Bureau will be monitoring the BHOs' progress towards the 85% standard monthly, with the Bureau reporting the progress to the Funding Board. The Bureau may require the BHO to submit a corrective action plan to demonstrate how it will meet the 85% on an annual basis. Any corrective action plan or reconciliation payments must be factored into the profit/loss calculations for the purpose of this profit/loss risk banding agreement.

Administrative costs will be audited for reasonableness only when the State is sharing in a loss.

The Bureau will be responsible for overseeing the administration of the risk banding methodology and will be responsible for clearly defining appropriate expenses to be included within each of the three categories:

- Medical Expense
- Administrative Expense
- Profit/Risk/Contingency

Reconciliation

Option 1 – Net Income/Net Loss Calculation
TennCare will calculate, a CONTRACTOR's net income/net loss under option 1 by subtracting covered services, premium tax and administrative expenses from an BHO's total TennCare revenue. TennCare revenue includes any additional income generated by investment income as a result of the deposit of the capitation payment from TennCare into an interest bearing account. If investment income attributable to the deposit of capitation payments from TennCare in an interest bearing account is not tracked due to the manner in which financial deposits are maintained, the CONTRACTOR must submit an allocation methodology for the determination of investment income to TennCare for approval prior to submission of the settlement calculation.All calculations on expenses must include any third party liability recoveries as a negative expense and include the net impact of any reinsurance program. If this calculation results in income (revenue exceeds expenses), only those expenditures below 98% of the total TennCare revenue, net of the premium tax, will be shared according to the tables above.

If the calculation results in a loss (expenses exceed revenues), only the expenditures above 102% of the total TennCare revenue, net of the premium tax, will be shared according to the tables above.

Option 2 – Net Income/Net Loss Calculation
TennCare will calculate, a CONTRACTOR's net income/net loss under option 2 by subtracting covered services, premium tax and administrative expenses from an BHO's total TennCare revenue. TennCare revenue includes any additional income generated by investment income as a result of the deposit of the capitation payment from TennCare into an interest bearing account. If investment income attributable to the deposit of capitation payments from TennCare in an interest bearing account is not tracked due to the manner in which financial deposits are maintained, the CONTRACTOR must submit an allocation methodology for the determination of investment income to TennCare for approval prior to submission of the settlement calculationAll calculations on expenses must include any third party liability recoveries as a negative expense and include the net impact of any reinsurance program. If this calculation results in income (revenue exceeds expenses), all expenditures below the 100% of the total TennCare revenue, net of premium tax, will be shared according to the tables above.

If the calculation results in a loss (expenses exceed revenues), all expenditures above 100% of total TennCare revenue, net of the premium tax, will be shared according to the tables above.

Section Four
Risk Banding Definitions

Administrative Costs

Costs that are non-medical in nature. In the event that the State shares in an BHOs losses, administrative costs will be audited for reasonableness in accordance with standards established by the Comptroller of the Treasury. Premium tax is considered to be an Administrative Cost.

Medical Expenses (Covered Medical Services)

1. The cost of providing TennCare Partners Program medical services to enrollees as identified and pursuant to the following listed subsections:
   a. 2.6 Covered Services
   b. 2.6.4 Case Management
   c. Covered services directed by TennCare or an administrative law judge
   d. Net impact of reinsurance coverage purchased by the BHO
2. Preventive Service: In order for preventive services in Section 2-3 (including, but not limited to, health education and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR'S enrollees or targeted to meet the enrollee's individual needs.
3. For the purposes of determining Medical Loss Ratio, Medical Expenses do not include:
   a. 2.6.8 Services Not Covered
   b. Services eligible for reimbursement by Medicare
   c. The activities described in or required to be conducted in Attachments B C D E F G H (including, but not limited to, utilization management, utilization review activities) are administrative costs.
4. Medical expense will be net of any third party liability recoveries or subrogation activities.
5. This definition does not apply to NAIC filings.

Medical Loss Ratio
The percentage of capitation payment received from TennCare that is paid for covered medical expenses net of third party liability recoveries and reinsurance premiums and recoveries.

NAIC

National Association of Insurance Commissioners

Net Income
Using the calculations described within the profit/loss Risk Banding Manual, when total TennCare revenues exceed total expenses, adjusting for the actual results of the actuarially certified claims runout.

Net Loss
Using the calculations described within the profit/loss Risk Banding Manual, when total expenses exceed total revenues, adjusting for the actual results of the actuarially certified claims runout.

TennCare Revenues
TennCare revenues includes capitation premium revenues paid by the State of Tennessee (State) to the contracted TennCare BHOs as well as investment income derived solely from a deposit of a capitation payment in an interest bearing account.

Section Five
Contract Terms

An BHO may change the risk band option by notifying the State in writing no later than December 31, 2000, and the subsequent risk band option will be effective January 1, 2001 through June 30, 2001. The BHO may change the risk band option again by notifying the State within seven (7) days of receipt of the recalibrated rates after the open enrollment period in 2001. The subsequent risk band will be effective from July 1, 2001 through December 31, 2001. The BHO may opt to change risk band options a final time by notifying the State in writing no later than December 1, 2001, and the subsequent risk band option will be effective January 1, 2002 through June 30, 2002.

TennCare reserves the right to modify the availability of the optional profit/loss risk-banding program prior to the beginning of each calendar year with the mutual agreement of the CONTRACTOR. BHOs who choose not to participate in the optional profit/loss risk banding program are at risk for 100% of any profit or loss resulting from participation in the TennCare program for the entire 1 ½ year period ending June 30, 2002.

The risk band options shall be calculated based upon services rendered to enrollees and expenses incurred by the contractor and the revenues received by the contractor for the applicable calculation period. The risk band option will be calculated for the settlement periods of January 1, 2001 through June 30, 2001, July 1 through December 31, 2001, and thereafter for calendar year periods.

All covered services as defined in Section 2.6 of the Contractor Risk Agreement will be included in the calculation of the risk band. Only those covered services incurred during a contract year and paid during or within six months after the end of a contract year will be included in the calculation of net income/loss.

Section Six: Sample Calculations

			Scenarios								
			A	B	C	D	E	F	G	H	I
		TARGETS							-	-	-
PREMIUM TAX		$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 2.00
MEDICAL LOSS RATIO		$ 85.00	$ 89.00	$ 89.00	$ 89.00	$ 81.00	$ 81.00	$ 81.00	$ 85.00	$ 85.00	$ 85.00
ADMINISTRATION		$ 13.00	$18.00	$10.00	$14.00	$18.00	$10.00	$14.00 0	$18.00	$10.00	$14.00
TOTAL PREM TAX + MLR + ADMIN			$ 108.00	$ 100.00	$ 104.00	$ 100.00	$ 92.00	$ 96.00	$ 104.00	$ 96.00	$ 100.00
Target Capitation = PREM TAX +		$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
Investment Income Earned		$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Total Target Capitation and Invest. Income		$101.00	$101.00	$101.00	$101.00	$101.00	$101.00	$101.00	$101.00	$101.00	$101.00
Final Income/(Loss)			$(4.00)	$4.00	-	$(4.00) -	$4.00	-	$ (4.00)	$ 4.00	$ -
MLR Reconciliation											
If MLR < 85%, Reconcile to 85%			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Risk Banding											
ADJ TOTAL PREM TAX + MLR + ADMIN			$105.00	$97.00	$101.00	$105.00	$97.00	101.00	$105.00	$97.00	$101.00
Risk Banding Income/(Loss)			$(4.00)	$4.00	$ -	$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -
Income/Breakeven/Loss			Loss	Income	Breakeven	Loss	Income	Breakeven	Loss	Income	Breakeven
Option 1	Total		$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -
	Shared		$ (2.00)	$ 2.00	$ -	$ (2.00)	$ 2.00	$ -	$ (2.00)	$ 2.00	$ -
	Income	Loss									
State	70%	50%	$ (1.00)	$ 4.00	$ -	$ (1.00)	$ 1.40	$ -	$ (1.00)	$ 1.40	$ -
BHO	30%	50%	$ (1.00)	$ 4.00	$ -	$ (1.00)	$ 0.60	$ -	$ (1.00)	$ 0.60	$ -
Option 2	Total		$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -
	Shared		$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ -	$ (4.00)	$ 4.00	$ BH-
	Income	Loss									
State	70%	50%	$ (2.00)	$ 2.80	$ -	$ (2.00)	$ 2.80	$ -	$ (2.00)	$ 2.80	$ -
BHO	30%	50%	$ (2.00)	$ 1.20	$ -	$ (2.00)	$ 1.20	$ -	$ (2.00)	$ 1.20	$ -

FRIENDS IN MENTAL HEALTH SERVICES

Alicia Fox
Tom Doub
Jane Thompson
Linda Graham
Becki Poling
Jo Ann Bennett
Bev Lewis
John Simpson
Dwen Westmoreland
Larry Thompson
Sandy Heath
Sue Hunt
Liz Ledbetter
Sandra Davis
Marthagem Whitlock
Melanie Harper
Melanie Hampton
Kathy Grimes
Louise Barnes
Betty Jackson
Janice Spillman
Jackie Talley
Dennis Wenner

AMENDMENT NUMBER ONE

PROVIDER RISK CONTRACT

BETWEEN

THE STATE OF TENNESSEE DEPARTMENT OF MENTAL HEALTH
DEVELOPMENTAL DISABILITIES AND

TENNESSEE BEHAVIORAL HEALTH, INC.

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Provider Risk Agreement by and between the State of Tennessee Department of Mental Health and Developmental Disabilities, herinafter referred to as TDMHDD, and Tennessee Behavioral Health, Inc. hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

A. PAYMENT TERMS AND CONDITIONS

1. Amend Section 4.7.1.1 **Capitation Rates** by deleting said section in its entirety and replacing it with the following language:

4.7.1.1 Capitation Rates

The following Capitation Rates and payment amounts shall be applicable to this CONTRACT.

For the period beginning June 7, 2001, the total amount of funding available for monthly capitation payments will be $27,605,439. Each month TennCare will calculate the number of TennCare enrolled **Priority Participants** in each BHO. Each BHO will receive the payment rate of $319.41 for each TennCare enrolled **Priority Participant** in its plan less any applicable adjustments for coinsurance. The remaining amount available from the monthly capitation payment will be divided by the remaining TennCare Partners Program **Participants**, including State only **Participants** described in Section 2.2.1.2 of this CONTRACT, who are

not enrolled in TennCare. A variable capitation rate will be determined for each of these **Participants** and paid to the BHO according to the number of **Participants** in its plan.

Effective June 7, 2001, the total amount of the funding available for the monthly capitation payment shall be the sum of (a) $27,605,439 and (b) $26.86 multiplied by the number of enrollees in excess of 1,225,000 on the report nearest May 31, 2001. Effective July 1, 2001, the total amount of funding available for the monthly capitation payment shall be $29,799,768

Adjustment to Capitation for Funding of New Programs

*The **Contractor** agrees to participate in any new programs designed by the State and to allow for adjustment to be made to the amount available for monthly capitation payments for enrollees covered under this agreement who are removed to form a new group. This adjustment is to account for the reduction in services the **Contractor** is required to cover or provide as a result of certain enrollees moving from this plan to another plan and shall be based only on the historical utilization of such enrollees. The amount and effective date of the adjustment will be determined by TENNCARE.*

2. Amend Section 4.7.1.2 **Basic Calculation** by renumbering it to 4.7.1.4 and inserting new language for section 4.7.1.2 Profit/Loss Risk Banding as follows:

4.7.1.2 Profit/Loss Risk Banding

The **Contractor** has the option of participating in a profit/loss risk-banding program as described in Options 1 or 2 below or may assume full risk under this Agreement. If the **Contractor** chooses risk-banding Options 1 or 2, it must provide written notice of this choice to the State by June 15, 2001. The risk band chosen will be applied from June 7, 2001 through June 30, 2002. The risk band options shall be calculated based upon services rendered to enrollees and expenses incurred by the **Contractor** and the revenues received by the **Contractor** during the applicable calculation period. If the **Contractor** does not choose a risk banding option by June 15, 2001, the **Contractor** will be at risk for the entire period ending June 30, 2002. TennCare reserves the right to modify and/or discontinue the availability of the optional profit/loss risk-banding program prior to the beginning of each contract year. BHOs that choose not to participate in the optional profit/loss risk banding programs are at risk for 100% of any profit or loss resulting from participation in the TennCare program. Calculations showing profit and loss shall be based upon generally accepted accounting principles, shall be submitted to the State within ninety (90) days of the ending six (6) month and yearly periods described herein, and shall be subject to final approval by TennCare in the event the profit/loss triggers a sharing of profit/loss under the option selected by the **Contractor**. The following options are available:

Option 1 - The **Contractor** is responsible for the first 2% of profit or loss. Profits and loss are calculated as a percentage of total TennCare revenue. TennCare will share in any profit or loss as described below. After a gain or loss of greater than 2% risk sharing is computed as follows:

Losses: For losses between 2-10 percent of TennCare revenue, the State will pay for 50% of the loss. For losses in excess of 10%, the State will pay the following percentages of loss:

June 7, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

Gains: For gains between 2-10 percent of TennCare revenue, the State will be paid 70% of the gain. For gains in excess of 10%, the State will be paid the following percentage of gain:

June 7, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

Option 2 – TENNCARE and the **CONTRACTOR** share in all gains and losses as defined below:

Losses: For losses up to 10%, the State will pay for 50% of the loss. For losses in excess of 10%, the State will pay the following percentages of loss:

June 7, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

Gains: For gains up to 10% of TennCare revenue, the State will be paid 70% of the gain. For gains in excess of 10%, the State will be paid the following percentage of gain:

June 7, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

B. RECORDS AND REPORTING REQUIREMENTS/FINANCIAL REPORTING

1. Amend Section 3.12.9.1 by adding new language related to the medical loss ratio report that will make this section read as follows:

3.12.9.1 The **Contractor** shall file with the TennCare Division of TDCI an annual report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated 56-32-208 . The annual report shall also contain an income statement detailing the **Contractor's** fourth quarter and year-to-date revenues and expenses incurred as a result of the **Contractors** participation in the State of Tennessee's TennCare Partners Program. The **Contractor** in preparing this annual report shall comply with any and

all rules and regulations of TDCI related to the preparation and filing of this report. Furthermore, the medical loss ratio report required in Section 3.15.8 must be filed with and reconciled to the NAIC annual statement.

2. Amend Section 3.12.9.2 by adding new language related to quarterly reports and NAIC filings that will make this section read as follows:

3.12.9.2 The **Contractor** shall file with the TennCare Division of TDCI a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These quarterly reports shall be filed on or before June 1 (covering first quarter of the current year), September 1 (covering the second quarter of the current year) and December 1 (covering third quarter of current year), of each calendar year. Each quarterly report shall also contain an income statement detailing the **Contractor's** quarterly and year-to-date revenues earned and expenses incurred as a result of the **Contractor**'s participation in the State of Tennessee's TennCare Partners Program. The medical loss ratio report required in Section 3.15.8 must be filed with and reconciled to the September NAIC quarterly report. The actuarial certification shall be prepared in accordance with the National Association of Insurance Commissioners' guidelines.

C. MONITORING AND AUDIT REQUIREMENTS

Amend Section 3.14.1 **Audit Requirements** to read as follows:

3.14.1 The **Contractor** shall also cause an audit to be performed by a licensed certified public accountant of its business transactions, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with General Accepted Auditing Standards. The **Contractor** shall submit to the Tennessee Department of Commerce and Insurance, TennCare Division, the audited financial statements (prepared under generally accepted accounting principles) covering the previous calendar year by May 1 of each calendar year. The audited financial statements shall include the following:

d. an income statement addressing the TennCare Partners Program operations of the **Contractor,**

e. a reconciliation of the audited financial statements to the National Association of Insurance Commissioners annual report filed with the Tennessee Department of Commerce and Insurance, TennCare Division, and

f. a summary of transactions between the **Contractor** and the **Contractor's** related parties, including a non-affiliated management company, using the format prescribed by TDCI. For the purpose of identifying the **Contractor's** related parties, "affiliate" and "control" shall have the same definitions as those set forth in Tennessee Code Annoted, Section 56-11-201 and the definition of "affiliate" set forth in T.C.A. Section 56-32-202.

The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in the TennCare Agreement, the TennCare Agreement takes precedent. These financial reporting requirements shall supersede any other reporting requirements required of the **Contractor** by the Tennessee Department of Commerce and Insurance, and the Tennessee Department of Commerce and Insurance shall enact any necessary rule or regulation to conform with this provision of the Agreement.

D. FISCAL MANAGEMENT

Amend Section 3.15 **Fiscal Management** by adding a new section 3.15.8 **Medical Loss Rates** which shall read as follows:

3.15.8 Medical Loss Rates

For the period June 7, 2001 through December 31, 2001, the **Contractor** is required to achieve medical loss ratio of no less than 88.25%* of capitation payments received from TennCare while new accountability measures are being developed. At such time as accountability measures are developed, implemented and it is determined by the State that said accountability measures are being met by the **Contractor**, the State may eliminate this requirement as an accountability measure for future Fiscal Years. The intent of the 88.25%* medical loss ratio is that 88.25 %* of the capitation rate will be spent on covered services as defined in Attachment B of the CONTRACT for eligible TennCare Partners Program enrollees. Medical loss ratio shall be reported monthly with cumulative year to date calculation using the form specified by TDCI. The **Contractor** shall report all behavioral health expenses and capitation payments received from TennCare. Monthly expenditures shall be reported by provider groupings including but not limited to (i) direct payments to providers for covered services, (ii) capitated payments to providers and (iii) subcontractors for covered services. The **Contractor** will submit these reports monthly, due by the 15th of the following month to TDMHDD and TDCI. The **Contractor** will also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. A reconciliation of the MLR report to the NAIC filing must be included.

The medical loss ratio requirement will be monitored monthly and reconciled to determine compliance. In the event the **Contractor** has not distributed 86% of its captiation rate for any month and it appears that the **Contractor** will not ultimately reach its target, as determined during monthly monitoring, the State may require the **Contractor** to submit a corrective action plan in compliance with Attachment H. In addition to the remedies specified in Attachment H, the State may order the **Contractor** to distribute to providers the difference between 88.25%* and the percentage distributed including projected distributions for incurred but not reported claims. At such time as accountability measures are developed, implemented and it is determined by the State that said accountability measures are being met by the **Contractor**, the State may eliminate this requirement as an accountability measure for future Fiscal Year.

An assessment of the **Contractor's** medical loss ratio will be made within ninety (90) days after June 30, 2002.

*****Effective January 1, 2002, the medical loss ratio will be 88%.

E. TITLE VI INFORMATION

1. Amend section 3.17 **Title VI Information** by deleting the first paragraph and replacing it with the following phrase:

   In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, the **Contractor** shall:

2. Amend section 3.17.1 by renumbering it to 3.17.2.

3. Amend section 3.17 **Title VI Information** by adding a new section 3.17.1 which shall read:

   3.17.1 Designate a staff person to be responsible for Title VI compliance on behalf of the **Contractor.** The designated staff person shall be identified by name in writing to TennCare on a quarterly basis. The **Contractor** does not have to require that Title VI compliance be the sole function of the designated staff person.

4. Amend section 3.17 by adding a new section 3.17.1.1 which shall read:

   3.17.1.1 In respect to any period of time that a **Contractor** does not have a designated staff person responsible for Title VI compliance it shall be reported to TennCare in writing within five (5) business days of the commencement of such period of time. The name of the re-designated staff person and date of re-designation is to be reported to TennCare within five (5) business days. (*The status is to be reported to TennCare's Title VI Coordinator.*)

5. Amend section 3.17.3 and 3.17.4 by deleting said sections in entirety and replacing with new sections 3.17.3, 3.17.4, 3.17.5, 3.17.6, 3.17.6.1 and 3.17.7 which shall read as follows:

   3.17.3 On a quarterly basis, submit a summary totaling listing the number of supervisory personnel by race/nation, origin and sex. The **Contractor** is required to request this information from all **Contractor** staff. **Contractor** staff response is voluntary. The **Contractor** is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by: number of male supervisors who are White males, Black males (not of Hispanic origin), American Indian or Alaskan Native males, Asian or Pacific Islander males, Hispanic origin males and other race/national origin males as indicated by staff and number of supervisors who are White females, Black females (not of Hispanic origin), American Indian or Alaskan Native females, Asian or Pacific Islander females, Hispanic origin females and other race/national origin female as indicated by staff.

3.17.4 On an annual basis, a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in 3.17.3) and shall be sorted by CSA. Each provider type (e.g. physician, dentist, etc.) shall be reported separately within the CSA. Primary care providers shall be reported separately from other physician specialties. The **Contractor** is required to request this information from all providers. Provider response is voluntary. The **Contractor** is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding participation in the **Contractor's** provider network or in determination of compensation amounts.

3.17.5 On a quarterly basis, a listing of all complaints/appeals filed by employees, enrollees and subcontractors in which discrimination is alleged in the **Contractor's** TennCare Plan. Such listing shall include, at a minimum, the identity of the complainant, the circumstances of the complaint/appeal, date complaint/appeal filed, the individual's relationship to the **Contractor, Contractor's** resolution, if resolved, and name of **Contractor** staff person responsible for adjudication of complaint/appeal.

3.17.6 On an annual basis, a copy of the **Contractor's** policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.

3.17.6.1 A listing of the interpreter/translator services utilized by the **Contractor** in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

3.17.7 On an annual basis, the **Contractor's** Title VI Compliance Plan and Assurance of Non-discrimination.

F. RISK BANDING

The CONTRACT is amended by adding a new attachment titled Profit/Loss Risk Banding. See Attachment H.

G. REQUIREMENTS REGARDING CONTRACTS AND SUBCONTRACTS

Amend Section 3.9.2.31 by deleting the entire section and replacing it with the following language:

3.9.2.31 Contain a provision setting forth that a Provider has a right to have claims that are partially or totally denied in a remittance advice or other appropriate written notice reviewed pursuant to T.C.A. 56-32-226(b) by an independent reviewer.

H. Miscellaneous Terms and Conditions

Amend Section 6.18.4 by changing the last sentence of the first paragraph to read as follows and amending the second paragraph to read as follows:

6.18.4 This CONTRACT shall be in effect from June 7, 2001 through June 30, 2002.

At the option of the State, this CONTRACT shall be automatically renewed for up to an additional twelve (12) months in three (3) months intervals, not to extend beyond June 30, 2003, under the same terms and conditions, unless the **Contractor** shall notify the State of the intent to terminate this CONTRACT pursuant to the terms of Section 5.1.6.8 of this CONTRACT.

I. Provider Requirements

Amend section 3.8.3 by deleting the entire Section

J. Standards for BHO Quality Monitoring Programs

Amend attachment C. standard VIII, B to read as follows:

Practitioners are credentialled initially (prior to delivery services) and are recredentialled at least every three years.

K. Use of Hospital Providers and Safety Net Providers

Amend Section 3.8.8.1 by deleting the following sentence:

The Contractor shall maintain a sufficient inpatient provider network, so no inpatient provider, especially the regional mental health institutes are forced to exceed their licensed capacity.

L. Quality Monitoring/Quality Improvement Program

Amend Section 3.11.3 to include reference to URAC (Utilization Review Accreditation Committee.

M. 10% Withholds

Amend Section 4.7.2 by adding the following sentence:

If the Contractor goes six (6) months without a withhold, the ten percent (10%) will be reduced to five percent (5%).

Amendment One to RE-ISSUED Contract

All of the provisions of the original agreement and subsequent amendments not specifically deleted or modified herein shall remain in full force and effect. This Amendment shall become effective upon HCFA approval unless otherwise specified in any section herein. To be effective the U.S. Department of Health and Human Services, Health Care Financing Administration must approve this amendment. The parties agree by executing this Amendment, that at such time as the Re-Issued Managed Care Contract between the **Contractor** and the State of Tennessee, Department of Mental Health and Developmental Disabilities, dated January 1, 2001 and subsequently amended is re-issued as a single replacement document, all parties will immediately execute the replacement copy.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

CONTRACTOR:

_____ _____

Charles D. Klusener DATE
President
Tennessee Behavioral Health, Inc.

TENNESSEE DEPARTMENT OF MENTAL
HEALTH AND DEVELOPMENTAL DISABILITIES

_____ _____

Elisabeth Rukeyser DATE
Commissioner

APPROVED:

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

_____ _____

C. Warren Neel, Ph.D. DATE

Commissioner

COMPTROLLER OF TREASURY:

_____ _____

John G. Morgan DATE
Comptroller of Treasury